Dear Sick Leave Bank Member,

Enclosed, you will find the Sick Leave Bank Guidelines/Release form, Sick Leave Bank Request Application, Certification of Health Care Provider for Employee’s Serious Health Condition (FMLA), and Employee Rights and Responsibilities Under The Family Medical Leave Act.

Please review the enclosed forms and return the completed application packet to the appropriate Sick Leave Bank chairperson no later than the last working day of the month of your request. All applications must include the following:

- Signed Sick Leave Bank Guidelines/Release Form

- Completed Sick Leave Bank Request Application
  - Indicate Sick Leave Bank applying to
  - Complete the “For Completion by the Employee” section, sign, and date.
  - Please have the physician fill out the portion “For Completion by the Health Care Provider”

- Completed “Certification of Health Care Provider for Employee’s Serious Health Condition (FMLA) form /(WH-380-E). This must be completed by the physician.

- In addition, please include a letter stating the estimated amount of sick leave days and reason for the request.

All forms must be completed and signed in order for the Sick Leave Bank to process your request.

Thank you.

If you have any questions regarding your Sick Leave Bank, please contact the following board chairperson:

➢ Board/Administrative (Certified & Classified Administrators, Certified & Classified Professionals and Allied Health Professionals): Michelle.Wilcox@d51schools.org or 254-5121.

➢ MVEA: Darren.Cook@d51schools.org or 242-6507.

➢ Nutrition Services: Debbv.Beasley@d51schools.org or 254-5186.

➢ Clerical (Paraprofessionals, Clerical, and Educational Interpreters): Julie.Bitner@d51schools.org or 254-5131.

➢ Custodial, Garage/Warehouse, Grounds, and Maintenance: Galvin.Gibson@d51schools.org or 254-5219.

If you have questions regarding unpaid leave or The Family Medical Leave Act (FMLA) please contact Michelle Wilcox (Michelle.Wilcox@d51schools.org) at 254-5121 or Julie Bitner (Julie.Bitner@d51schools.org) at 254-5131.
Licensed Covered Employee (MVEA)

Sick Leave Bank

Guidelines/Release Form

The MVEA Sick Leave Bank, hereinafter referred to as the Program, has been established to provide extra sick leave days for members experiencing extraordinary or severe illness, injury, impairment, or physical or mental condition who have exhausted their sick leave. In order to qualify for the Program, you must be a district employee working a permanent position. Membership in the Program is voluntary. Only qualifying members of the Program may receive donations from the Program. The Program will operate under the following provisions and conditions:

1. A Sick Leave Bank Program Board, hereinafter referred to as Program Board, shall be established and will be the governing body for the Program. The Program Board shall consist of six (6) voting members from the Association, selected by the Association, and one (1) non-voting ex officio member who shall be the Executive Director of Human Resources of the District. It shall be the responsibility of the Program Board to judiciously administer the provisions of the Program and to safeguard against the capricious use of the Program.

2. Enrollment periods for the Sick Leave Bank shall be the month of September each year. During these periods, any Covered Employee may enroll by completing the required form and contributing two (2) days sick leave. Employees new to the District may enroll within thirty (30) days of employment. The District will contribute two (2) days to the Sick Leave Bank on behalf of any new employee who attends the two (2) non-compensated training days before the beginning of the contract year.

3. A member of the Program may terminate membership by completing a required form provided by the Program Board during the enrollment period each year; however, the days contributed by the terminating employee may not be withdrawn.

4. In order for the Program Board to evaluate whether an application qualifies for Program days, the member must sign a release stating that members of the Program Board will be authorized to receive information regarding the nature and extent of the applicant's condition. Program Board members will keep all such information confidential.

5. A member shall use his/her accumulated day leave days prior to utilizing days which may be provided by the Program.

6. The Program Board may grant one (1) to sixty (60) days each school year to an individual member requesting days from the Program. If the Program Board, following an examination of the individual situation, determines that the circumstances are unusual and merit an extension, an extension of one (1) to thirty (30) days may be granted. It is understood that the Program Board has the authority to deny any request. In such instance, the Program member may appeal in accordance with Section 10.12. Use of sick leave bank days is limited to ninety (90) days per specific illness per member. Days used from the Program by members will not have to be replaced by the member.

7. Days provided by the Program can only be withdrawn from the Program for a member's illness or injury.

8. Request for use of Program days must be submitted in writing to the Program Board, accompanied by the following:
   a. A letter from the attending physician explaining the illness or injury.
   b. A past history of sick leave/day leave used by the employee.
   c. The employee's expected date for return to work.
   d. Any other pertinent information requested by the Program Board.

September 2012
9. If the days in the Program on September 1 of any year are less than two (2) times the number of Program members, each member shall contribute no less than one (1) additional day of leave. In no case, shall the number of days in the Program, as of September 30 of any year, be less than two (2) times the number of Program members.

10. The Program Board may recommend such reasonable rules and regulations as it deems necessary to administer this plan for adoption by the Association. Copies of rules, regulations, and procedures will be provided to the District.

11. Decisions of the Program Board may be appealed to the Executive Council of the Association. Decisions rendered by the Executive Council are not subject to the grievance or arbitration procedures identified in Section 6 of this Agreement and further, this appeal procedure is considered to be the exclusive remedy for a program member who has appealed the Program Board decision.

12. Copies of all correspondence, applications, and any other material submitted to the Program Board for consideration of an individual member’s application, shall become a part of the individual member’s file of the District.

I, __________________________, authorize members of the MVEA Sick Leave Bank to review medical information regarding the nature and extent of my illness/injury. I understand that all such information will be kept confidential.

____________________________  __________________________
Signature                                                                 Date

The members of the MVEA Sick Leave Bank Board promise to keep all medical information regarding this member’s illness/injury confidential.

____________________________  __________________________
Sick Leave Bank Board Chairman                                                Date

Copies to: White – Human Resources; Canary – Payroll; Pink – Employee

September 2012
SICK LEAVE BANK REQUEST APPLICATION
(PLEASE PRINT)

I am applying to the... (Please select one below)
☐ Board/Administrative Sick Leave Bank (includes Certified & Classified Administrators, Certified & Classified Professionals, and Allied Health Professionals)
☐ Mesa Valley Education Association (MVEA) Sick Leave Bank
☐ Nutrition Services Sick Leave Bank
☐ Clerical Sick Leave Bank (includes Paraprofessionals, Clerical, and Educational Interpreters)
☐ Custodial, Garage/Warehouse, Grounds, and Maintenance Sick Leave Bank

FOR COMPLETION BY THE EMPLOYEE

Name: _________________________________ Employee ID #: ________________

Last                                      First
Address: _______________________________ Phone: __________________________

Street                        City        State        Zip
Position: _______________________________ Location: ________________________

Scheduled Work Hours/Days: ______________

If applicable, I would like to use my vacation for any required waiting period.  ☐ Yes  ☐ No

I request a block of time leave from ___________ to ___________. I wish to apply for ________ hours/days of Sick Leave

(M/D/YY)                          (M/D/YY)

Bank days. By signing this application, I authorize and give my consent for the District’s Human Resources Department
to release and disclose my health care provider’s Family and Medical Leave Act Certification (Form WH-380-E) and any
other information and records in its possession regarding my illness, injury or other health condition to the members
of the above-selected sick leave bank board for the purpose of evaluating my request for sick leave bank benefits.

___________________________________________        __________________________
Employee’s Signature                        Date

FOR COMPLETION BY THE HEALTH CARE PROVIDER

***Please complete the attached Family Medical Leave Act form***

I certify that ___________________________________________ has been under my treatment and care and has
been unable to perform assigned duties since ____________________________________________.

Approximate date employee can return to work: ________________________________

Health Care Provider Name (Please Print): ________________________________ Phone: __________________

Health Care Provider Address: ______________________________________________

___________________________________________        __________________________
Health Provider’s Signature                        Date

FOR THE BOARD USE ONLY

Member has _______ hours/days accumulated personal sick leave/day leave available as of ________________

Beginning date of Sick Leave Bank use: ________________ Is there a 3 day waiting period?  ☐ Yes  ☐ No

Total hours/days charged to Sick Leave Bank: ________________ hours/days

ACTION**:  Approved ___________ Denied ___________

Reason: ________________________________________________________________

___________________________________________        __________________________
Signature of Chairperson/Board Member:                        Date:

**If health care provider releases employee to return to work earlier than anticipated, the remainder of Sick Leave Bank hours/days
will be returned to the Bank.

Copies to: White – Payroll; Canary – Human Resources; Pink – Sick Leave Bank; Goldenrod – Member

Revised 3/12
SECTION I: For Completion by the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee’s health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees 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.

Employer name and contact: **Mesa County Valley School District 51 – Michelle Wilcox, 254-5121**

Employee’s job title: ____________________  Regular work schedule:  **Monday – Friday**

Employee’s essential job functions: ________________________________________________

Check if job description is attached: ____

SECTION II: For Completion by the EMPLOYEE

INSTRUCTIONS to the Employee: Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: ________________________________    First  Middle  Last

SECTION III: For Completion by the HEALTH CARE PROVIDER

INSTRUCTIONS to the HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. 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 FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider’s name and business address: ________________________________________________

Type of practice / Medical specialty: ________________________________________________

Telephone: (_______) ______________________ Fax: (_______) _______________________
PART A: MEDICAL FACTS

1. Approximate date condition commenced: ________________________________

Probable duration of condition: ________________________________

Mark below as applicable:
Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

___ No    ___ Yes.   If so, dates of admission: ________________________________

Date(s) you treated the patient for condition: ________________________________

Will the patient need to have treatment visits at least twice per year due to the condition? ___ No   ___ Yes.

Was medication, other than over-the-counter medication, prescribed? ___ No   ___ Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

___ No    ___ Yes.   If so, state the nature of such treatments and expected duration of treatment:

________________________________________________________________________

2. Is the medical condition pregnancy? ___ No    ___ Yes.   If so, expected delivery date: ________________________________

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee’s essential functions or a job description, answer these questions based upon the employee’s own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition? ___ No    ___ Yes.   If so, identify the job functions the employee is unable to perform:

________________________________________________________________________

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? __No __Yes.

If so, estimate the beginning and ending dates for the period of incapacity: ____________________________

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee’s medical condition? __No __Yes.

If so, are the treatments or the reduced number of hours of work medically necessary? __No __Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period: ____________________________________________

Estimate the part-time or reduced work schedule the employee needs, if any:

________ hour(s) per day; ________ days per week from __________ through __________

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? __No __Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups? __No __Yes. If so, explain: ____________________________

Based upon the patient’s medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s)

Duration: _____ hours or _____ day(s) per episode

ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Signature of Health Care Provider: ____________________________ Date: ____________________________
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 childbirth;
• 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
other qualifying exigencies. Qualifying exigencies may include attending
certain military events, arranging for alternative childcare, addressing
personal financial and legal arrangements, attending counseling sessions,
and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible
employers to take up to 26 weeks of leave to care for a covered
servicemember during a single 12-month period. A covered servicemember
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 servicemember medically
 unfit to perform his or her duties for which the servicemember 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 with 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 days 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 employee 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 promoting 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
supercede 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.

For additional information:
WWW.WAGEANDHOUR.DOL.GOV

U.S. Department of Labor | Employment Standards Administration | Wage and Hour Division

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