Arlington INDEPENDENT SCHOOL DISTRICT
More Than a Remarkable Education

Medical Leave Request Form: Non-Certified

All medical leave request should be made at least 30 days prior to the date leave is set to begin (if possible). Any medical leave approved will require the use of all applicable paid leave time available to the employee.

Name _____ Phone _____

Job Title/Position _____ Hire Date _____

Location/School _____ Employee ID#_____

Date of Request _____ Supervisor/Principal _____

Estimated Leave Start Date _____/_____ /_____ Estimated Return to Work Date _____/_____/_____

CHECK ONE	Reason for Absence	Documentation Necessary	Completed by HR Specialist	
			Approved	Denied
	Family Medical Leave (FMLA) Employees who have been with district for at least 12 months, and have worked 1,250 hours in immediate preceding 12 months from date of leave. Limited to medical leave for employee's illness or illness within the employee's family as defined by the Family Medical Leave Act. FMLA runs concurrently with other leaves. Maximum length is 12 work weeks. **Leave Type: □ Continuous □ Intermittent** **Qualifying Event: □Self–Serious Health Condition □Birth/Bonding □Placement-Adoption/Foster Care □Care for a Family Member**	**Medical certification completed by your treating physician** – form is provided by the HR Specialist to the employee when eligibility is determined.		
	Temporary Disability Leave (TDL) Non-certified employees who are not eligible for FMLA, or who have exhausted FMLA and not medically able to return to work. TDL can only be used for the employee's own serious health condition or birth of a child. Maximum length of TDL is up to 96 calendar days for non-certified employees and must be used continuously. TDL runs concurrently with other leaves. **Qualifying Event: □Self–Serious Health Condition □Birth**	**Medical certification completed by your treating physician** – form is provided by the HR Specialist to the employee when eligibility is determined.		

Employees out for their own medical condition will not be permitted to resume work with the District until a medical release has been received by the HR Benefits Department. If you are out to care for a spouse/parent/child, you must notify the HR Benefits Department and your supervisor of your return date prior to your return.

I understand that the leave I am requesting is an unpaid leave except where use of sick leave, personal days, vacation days, compensatory time, worker's compensation, or paid assault leave are required. Any days taken where leave is unavailable are taken without pay. I understand that the District requires use of all accumulated state sick leave, local sick leave, state personal leave, vacation and compensatory time during leave. I understand that the leave begins on the date specified and shall run concurrently with FMLA and Temporary Disability Leave (TDL) as it applies.

I understand that while I am on FMLA, the District will continue to pay its contribution toward my medical insurance premium for a maximum of twelve weeks as covered under the Family Medical Leave Act, and I am responsible for continued payment of my portion of the medical premium. I understand that while I am on TDL, the District will not continue to pay its contribution toward my medical insurance premium.

I understand that I will not be permitted to resume my position with the District until I provide a doctor's medical release, specifying the date that I am released to return to work with or without reasonable accommodations. I understand that if I do not return to work after I have exhausted my 12 weeks of leave under FMLA and/or Temporary Disability Leave, I may have to resign. I have read and understand District Policy DEC (LOCAL). I attest that the above information is true and correct. I have read and understand the terms and conditions of my leave.

Employee Signature_____ **Date**_____

I acknowledge receiving this notification that the above employee is requesting to take a medical leave of absence under FMLA or Temporary Disability and understand that the request is subject to the approval of the HR Benefits Department.

Principal/Supervisor Signature _____ **Date**

The completed form may be faxed (682-867-4651) or scanned & emailed (pwhitesi@aisd.net) to the AISD HR Benefits Department

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Notice of Temporary Disability Leave

Employee Name: _____ **Employee #** _____

Position: _____ **Location:** _____

An employee who is not eligible for FMLA will be entitled to Temporary Disability Leave. If an employee will be out of work 3 days or more due to a serious health condition or for birth of a child, they may request Temporary Disability Leave.

Employees may take Temporary Disability Leave for up to 96 calendar days. During this leave, your position is no longer protected and you may be replaced. If released to return to work during Temporary Disability Leave, you may be placed into a similar position with AISD if one is available at the time of your release. If this extended leave time has been exhausted, and you have not been released to return to work, your position with AISD will be recommended for termination.

While on Temporary Disability Leave, AISD may terminate my insurance benefits for failure topay my portion of the medical insurance premiums.

The Temporary Disability Leave request must be obtained by contacting the AISD Benefits Department at least 30 days prior to beginning leave (if the need for leave is foreseeable). If the necessary paperwork is not requested and returned within a reasonable amount of time from when absences begin, your request may be denied and your employment could be terminated.

By signing this document I acknowledge that I have read and understand the above information regarding Temporary Disability Leave and my job status during this leave.

Employee Name: _____
Please Print Name

Employee Signature: _____ **DATE:** _____

If you have any questions, please contact the HR Benefits at pwhitesi@aisd.net

Return the completed form to Arlington ISD HR Benefits
Email: pwhitesi@aisd.net **or Fax (682)867-4651**

Arlington Independent School District
Certification of Health Care Provider Form
Temporary Disability Leave

Employee's name:	**Patient's name:**
Employee's Department	**Employee's Position**

The section below should be completed by the Attending Physician or Practitioner:
The information requested on this form relates only to the *serious health condition* for which the employee is requesting leave.
Please check the applicable category of the patient's qualifying condition:

☐ **Hospital Care** **Admission to Hospital Date: _____ Discharge Date: _____**

☐ **Serious Health Condition (Absence Plus Treatment)**

☐ **Birth of a Child** **Estimated Date of Delivery _____**

1. **Length of time your patient has had/will have this condition (Keeping the employee from essential functions of his/her job):**

   From: _____ Through: _____

2. **Describe the health condition and regimen of treatment to be prescribed indicating the number of visits, general nature and duration of treatment, and including referral to other provider(s) of health services.**

Print of Type Name of Healthcare provider:	
Type of Practice:	
Street & Mailing Address:	
Telephone Number:	**Fax Number:**
Signature of Healthcare Provider:	**Date:**

Return form to: HR Leaves
Email: pwhitesi@aisd.net Fax: (682) 867-4651
Arlington ISD Benefits, 1203 W. Pioneer Pkwy., Arlington, TX 76013

Revised 2/26/18

ARLINGTON INDEPENDENT SCHOOL DISTRICT
FITNESS-FOR-DUTY CERTIFICATION
(To be submitted prior to reinstatement)

Employee Name: _____Position_____

Campus/Department: _____

Employee's serious health condition which caused him/her to take a medical leave of absence:

_____

_____

Date leave commenced: _____Date leave is set to end: _____

Health Care Provider: I have reviewed the attached job description for this employee. _____ Initial

IS THE EMPLOYEE ABLE TO PERFORM THE ESSENTIAL FUNCTIONS OF HIS/HER JOB? ___YES ___NO

☐ The employee is able to work a full, regular schedule with no restrictions, beginning _____(date)

☐ The employee is able to return to work on a reduced schedule for _____ hours a day
From _____ (date) through _____ (date)

☐ The employee is able to return to work with restrictions from_____ (date) through_____(date).

Please indicate restrictions, if any, below for:

Standing (number of hours): _____ Walking (number of hours): _____

Sitting (number of hours): _____ Lifting (number of pounds): _____

Carrying (number of pounds): _____ Repetitive motion, pushing, pulling: _____

Any other restrictions: _____

_____

_____

Are the Restrictions Permanent? ____ YES ____ NO

_____

Signature of Health Care Provider: _____

Printed Name of Health Care Provider: _____

Date: _____Phone:_____

Please return completed form to the HR Benfits Department via email: pwhitesi@aisd.net, Fax: 682-867-4651 or mail: 1203 W. Pioneer Pkwy, Arlington, TX 76013

THIS IS A CONFIDENTIAL RECORD AND IT SHALL BE MAINTAINED AS SUCH

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HIPAA AUTHORIZATION FORM

Employee's Full Name	**Social Security Number**
Address	**Employee ID Number**
City, State Zip Code	**Date of Birth**
Telephone Number	**Email**

I authorize the use or disclosure of my protected health information as described below.

1. The specific information that should be disclosed is (please give dates of service if possible):

   FMLA and/or Extended leave status updates
2. The following person (or class of persons) is authorized to use or disclose my protected health information:

   Arlington Independent School District Benefits Department
3. The following person (or class of persons) may receive disclosure of protected health information about me:

   Arlington Independent School District Benefits Department

I understand that the use of disclosure of the requested information in this authorization will not result in direct or indirect compensation to the health care provider from a third party.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **AISD Benefits at** hrleaves@aisd.net. I also understand that my revocation is not effective to the extent that the persons I have authorized to use or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and may, in fact, refuse to do so.

I may inspect or copy the protected health information sought to be used or disclosed in this authorization, as permitted by the federal privacy regulations.

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

This authorization expires on _____. If not indicated, it will expire a year from signature date.

_____ _____

Signature of Individual or Personal Representative **Date**

_____

Printed Name

_____

Description of Personal Representative's Authority