LEAVE of ABSENCE

CATASTROPHIC VS FMLA LEAVE REQUIREMENTS

Many times employees find themselves facing an unexpected, long-term illness or life event, or perhaps need to step aside to care for immediate family members. When these situations arise, and the employee will be out for more than **10** consecutive days, they should provide their Principal/Supervisor with appropriate information in order to cover the responsibilities of the classroom and/or job.

CATASTROPHIC LEAVE

1. Complete the ***Request for Leave form***, indicating all options that apply, in order to account for the days you will be away from your job.

2. If you are a member of the Sick Bank you can apply for Catastrophic Leave. Upon submission of the ***FMLA and Catastrophic Sick Leave Request*** form, accompanied by the appropriate ***Physician's Form for Maternity Leave*** or ***Physician's Form for Medical Leave,*** your catastrophic request will be presented to the Board for approval. Once approved, Dr. Lowry will send the request to the Sick Bank Committee members at each school and opportunities to donate days on your behalf will be solicited. It is important to note that donated days will not be awarded until all Of your sick days, personal leave and/or vacation days have been exhausted. (A catastrophic illness is any illness, injury, pregnancy, or a medical condition related to pre-childbirth, certified by a licensed physician, which causes the member to be absent from work for an extended period of time.

Family Medical Leave Act (FMLA)

1. In order to qualify for FMLA you must be employed by Homewood City Schools for at least 12 months or more. FMLA entitled an eligible employee to take unpaid, job-protected leave for specified family and medical reasons, with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave. It is understood that any sick, personal and/or vacation leave will run concurrently from the date of first absence as long as the need results from one of the qualifying reasons under FMLA. *(Qualifiers include birth/care of newborn child, adoption, foster care placement with employee, care for immediate family member with a serious health condition, or medical leave when the employee is unable to work due to a serious health condition.*

2. Complete the ***Request for Leave form***, indicating all options that apply, in order to account for the days you will be away from your job.

3. Because FMLA requests also require Board approval it is necessary to complete the ***FMLA and Catastrophic Sick Leave Request form*** and corresponding ***Physicians Form (Maternity or Medical)*** **PRIOR** to your requested absence when possible.

4. Return all forms to Dayna Borden at the Board Office. dborden@homewood.k12.al.us or call 205.877-4549 with any additional questions.

REQUEST for LEAVE
Personal – Professional – Sick/Maternity

Please Print:

Employee's Full Name _____ School _____

Request is hereby made for _____ day(s) Date(s) _____

PERSONAL LEAVE
(check all that apply)

☐ Day 4 ____ Day 5

Will you need a Sub? _____

Personal Leave Days 4 & 5
Your signature serves as your acknowledgment that a daily substitute fee will be deducted from your next month's payroll.

PROFESSIONAL LEAVE

Purpose of Professional Leave _____

Location _____

Will you need a Sub? ___

Funding Source for Sub:
____ School Allocation for PD
____ Other (specify) _____
_____

☐ **No** Sub Employed

SICK/MATERNITY LEAVE
For Maternity Leave, or Sick Leave expected to last more than 5 days, will you be using:

☐ Sick Days
☐ Vacation Days
☐ Personal Days
☐ FMLA/Catastrophic (once Board Approved)

If applicable, attach the ***FMLA & Catastrophic Sick Leave Request***, along with the appropriate supporting ***Physician's Form***

_____
Employee's Signature Date

PERSONAL DAYS

____Day 4 ____Day 5

_____ _____
Principal's Signature ** Date

____ Approved: ____Disapproved

_____ _____ Day 5 only _____
Superintendent's Signature Date

____ Approved: ____Disapproved

** Send to: Dayna Borden – Sick Leave, FMLA/Catastrophic form, Dr. Note, 5th Personal Day
Laura Johnston – 4th Personal Day, Professional Leave

Revised 10.10.2024

FMLA and Catastrophic Sick Leave Request

To request Catastrophic and/or FMLA please complete this form, attach a physician's statement with the approximate effective dates/timeframe and submit to Dayna Borden at the Homewood Board of Education (dborden@homewood.k12.al.us, or fax 205-877-4544). Both requests require board approval and should be submitted PRIOR to the requested time off.

Please Print:

Employee's Full Name _____ School _____

Beginning Date _____ Approximate Ending Date _____

Please select all that apply:

____ As a member of the HCS Sick Bank, I am requesting **Catastrophic Sick Leave** and understand that donated days, if approved by the Sick Bank Committee, will not be awarded until all my sick days, personal leave and/or vacation days have been exhausted. (*A catastrophic illness is any illness, injury, pregnancy, or a medical condition related to pre-childbirth, certified by a licensed physician, which causes the member to be absent from work for an extended period of time.*)

_____ I am requesting coverage under the Family Medical Leave Act (**FMLA**) and acknowledge that I have worked for HCS for at least 12 months or more. I understand that any of my sick, personal and/or vacation leave will run concurrently from the date of first absence as long as the need results from one of the qualifying reasons under FMLA. *FMLA qualifiers include birth/care of newborn child, adoption/foster care placement with employee, care for immediate family member with a serious health condition, or medical leave when the employee is unable to work due to serious health condition.*

_____ _____

Date Employee Signature

Office Use:

Rec'd Dr. Note: PAS: SLB notice:

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PHYSICIAN'S FORM TO ACCOMPANY REQUEST FOR MEDICAL LEAVE

NOTE TO PHYSICIAN: We need your assistance to process a medical leave request from one of your patients. Your answers will help determine how much tie the employee needs to be away from work, or if work duties need to be altered upon returning to work. Based on eligibility for leave under FMLA, additional medical certification may be requested to process this request. Please answer the following questions to the best of your knowledge.

Name of Patient _____

Nature of Illness_____

Probable duration of condition/dates of leave _____

Will patient be able to perform normal work duties upon returning? ____ Yes ____ No

If **NO,** what are the work restrictions/accommodations for this person and anticipated dates these may apply?

_____

_____

_____

Will the employee need to attend follow-up treatment appointments or work a reduced schedule due to the medical condition?

_____

_____

_____

(If the patient's job duties/responsibilities are needed to complete this form, please contact HCS HR Department at 205-870-4203.)

_____

Signature of physician Printed Name Date

_____

Office Address Office Phone Number