Division of Human Resources

Request for Leave of Absence:
Medical Leave (Employee's Own Serious Health Condition)

801 N. 11th Street **St. Louis, MO 63101** **Phone: (314) 345.2379** **Fax: (314) 244.1739**

REQUEST FOR LEAVE OF ABSENCE

Request for leave must be made at least thirty (30) days prior to the date the requested leave is to begin, or as soon as practicable under the circumstances.

COMPLETED FORMS CAN BE RETURNED IN-PERSON, U.S. MAIL OR FAX (314) 244-1739

PLEASE PRINT:

Today's Date: _____ Employee Number: _____ Supervisor: _____

Employee Name: _____ Location/Position: _____

Will your contact information be different, during this leave period, from what is currently on file with the district? ☐ Yes ☐ No
If yes, please provide your contact information (street, city, state, postal code, phone number):

_____

If you are taking a paid leave, please indicate the following: ☐ PTO ☐ Vacation ☐ Sick Bank _____ Number of Days

I am requesting an EXTENSION of a previously approved leave of absence: ☐ Yes ☐ No (If yes, date current leave expires: _____)

MY REQUEST FOR LEAVE IS FOR THE FOLLOWING REASON: (please check one)

☐ **Birth of my child and/or in order to care for my child** Expected Date of Birth _____
Leave Start Date: _____ Expected Date of Return to Work: _____

☐ **Placement of a child for adoption or foster care** Expected Date of Placement _____
Leave Start Date: _____ Expected Date of Return to Work: _____

☐ **Care for my spouse, child or parent with a serious health condition***
Leave Start Date: _____ Expected Date of Return to Work: _____

☐ **My own serious health condition***
Leave Start Date: _____ Expected Date of Return to Work: _____

☐ **Any qualifying exigency arising out of the fact that my spouse, child, or parent is on active military duty, or has been notified of any impending call to active duty status, in support of a contingency operation**
Leave Start Date: _____ Expected Date of Return to Work: _____
Nature of the Exigency _____

☐ **Care for my spouse, child, parent, or next of kin who is a covered service member recovering from a serious illness or injury in the line of duty on active military duty****
Leave Start Date: _____ Expected Date of Return to Work: _____

☐ **Education Leave** **Supervisor/Principal Initials (*required for short-term Educational Leave only*):** _____
Five days or less *- should be sent to your direct supervisor for approval. Your paperwork should be kept on file at your school site once approved by your supervisor. Your supervisor's initials indicate approval for short-term Educational Leave.*
More than five days *– should be sent to Human Resources for approval and processing.*
Leave Start Date: _____ Expected Date of Return to Work: _____

☐ **Military Leave**
Leave Start Date: _____ Expected Date of Return to Work: _____

☐ **Other (including Non-FMLA Eligible Medical Leave)**
Leave Start Date: _____ Expected Date of Return to Work: _____

☐ **Sabbatical Leave**
Please select one of the following: ☐ for study ☐ for travel ☐ combination of study and travel
Leave Start Date: _____ Expected Date of Return to Work: _____

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* Medical certification is required for all leaves due to a "serious health condition". Certification must include the date on which the condition began; the probable duration of the condition; the relevant medical facts and expected course of treatment; a statement that the employee is needed to care for an immediate family member (i.e., the employee's spouse, child or parent), or that the employee is unable to perform the essential functions of his/her job. Failing to provide medical certification will result in a delay of leave until such certification

is obtained or denial of leave if no certification is provided. Further, an employee taking leave for his/her own serious health condition will be required to present medical certification of their "fitness-for-duty" to return to work, following the period of leave.

**The recovering service member must be a member of the Armed Forces (including the Reserves and National Guard) who is undergoing medical treatment, recuperation or therapy, is on out-patient status or is otherwise on a temporary disability retired list, for a serious injury or illness. A "serious injury or illness" is one incurred while on active duty in the Armed Services that renders the service member unable to perform his/her military duties.

ADDITIONAL INFORMATION REQUIREMENTS

***Education Leave** – The institution of higher education must be identified and proof of acceptance for study at the institution must be provided. A list of courses to be taken and the degree sought, if any, must be included in the detailed plan. **An employee can remain on this type of leave for up to one year, not to exceed one year.**

***Military Leave** – Orders / Amended Orders. **An employee can remain on this type of leave for up to 5 years, not to exceed 5 years** unless required by law**.**

***Sabbatical Leave** – If the request is for travel, a detailed analysis of the travel experience planned must be provided, which includes sites to be visited, purpose and anticipated dates of visits. Upon return, a synopsis will be required of how the travel benefited the St. Louis Public School District. If the request is for study, the institution of higher education must be identified and proof of acceptance for study at the institution must be provided. A list of courses to be taken and the degree sought, if any, must be included in the detailed plan. If the request is for a combination of study and travel, the applicant must comply with all the aforementioned items. **An employee can remain on this type of leave for up to one year, not to exceed one year.**

***Other type of Leave** – Documentation specifying need. If for a medically related reason (and the leave does not qualify as FMLA leave), medical certification is required. The medical certification must include information sufficient to determine whether the requested leave is reasonable and appropriate, including the date on which the condition began; the probable duration of the condition, the diagnosis and expected course of treatment; a statement that the employee is unable to perform the essential functions of his/her job. Failing to provide medical certification will result in a delay of leave until such certification is obtained or denial of leave if no certification is provided. Further, the employee will be required to present medical certification of their "fitness-for-duty" to return to work, following the period of leave. **An employee can remain on this type of leave for up to one year, not to exceed one year.**

****The employee will be responsible for payment of his/her portion of the benefit premiums****

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THIS SECTION TO BE COMPLETED FOR *MEDICAL LEAVE ONLY* (Own Serious Health Condition or Care for Immediate Family Member):

I am requesting ***intermittent leave*** or leave on a reduced leave schedule.

☐ Yes ☐ No If yes, provide the information requested below.

The estimated schedule I would like for this leave is:

The reasons for requesting this schedule are:

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Do you have a spouse who is employed by Saint Louis Public Schools? ☐ Yes ☐ No Spouse name/Employee # _____

If yes, has he/she taken a leave under this policy within the last 12 months? ☐ Yes ☐ No

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I am aware that the above information is not all-inclusive. I have read the Special Administrative Board's Employee Information relating to my requested leave and I understand my rights and obligations therein.

_____	_____
Employee Signature	Date
_____	_____
Human Resources	Date
_____	_____
Associate Superintendent (if applicable)	Date
_____	_____
Superintendent of Schools (if applicable)	Date

HR Use:

FMLA Eligible ☐ Yes ☐ No

Leave Status ☐ Approved ☐ Denied

Certification of Health Care Provider for Employee's Serious Health Condition under the Family and Medical Leave Act

U.S. Department of Labor
Wage and Hour Division

WAGE AND HOUR DIVISION

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

OMB Control Number: 1235-0003
Expires: 6/30/2023

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. 29 U.S.C. §§ 2613, 2614(c)(3); 29 C.F.R. § 825.305. The employer must give the employee **at least 15 calendar days** to provide the certification. If the employee fails to provide complete and sufficient medical certification, his or her FMLA leave request may be denied. 29 C.F.R. § 825.313. Information about the FMLA may be found on the WHD website at www.dol.gov/agencies/whd/fmla.

SECTION I – EMPLOYER

Either the employee or the employer may complete Section I. While use of this form is optional, this form asks the health care provider for the information necessary for a complete and sufficient medical certification, which is set out at 29 C.F.R. § 825.306. **You may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308.** Additionally, you **may not** request a certification for FMLA leave to bond with a healthy newborn child or a child placed for adoption or foster care.

Employers must generally maintain records and documents relating to medical information, 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, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

(1) Employee name: _____
First *Middle* *Last*

(2) Employer name: _____ Date: _____ *(mm/dd/yyyy)*
(List date certification requested)

(3) The medical certification must be returned by _____ *(mm/dd/yyyy)*
(Must allow at least 15 calendar days from the date requested, unless it is not feasible despite the employee's diligent, good faith efforts.)

(4) Employee's job title: _____ Job description (☐ is / ☐ is not) attached.
Employee's regular work schedule: _____
Statement of the employee's essential job functions: _____
_____
(*The essential functions of the employee's position are determined with reference to the position the employee held at the time the employee notified the employer of the need for leave or the leave started, whichever is earlier.)*

SECTION II - HEALTH CARE PROVIDER

Please provide your contact information, complete all relevant parts of this Section, and sign the form. Your patient has requested leave under the FMLA. The FMLA allows an employer to require that the employee submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to the serious health condition of the employee. For FMLA purposes, a "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves *inpatient care* or *continuing treatment by a health care provider*. For more information about the definitions of a serious health condition under the FMLA, see the chart on page 4.

You may, but are **not required** to, provide other appropriate medical facts including symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment. Please note that some state or local laws may not allow disclosure of private medical information about the patient's serious health condition, such as providing the diagnosis and/or course of treatment.

Employee Name: _____

Health Care Provider's name: *(Print)* _____

Health Care Provider's business address: _____

Type of practice / Medical specialty: _____

Telephone: (___) _____ Fax: (___) _____ E-mail: _____

PART A: Medical Information

Limit your response to the medical condition(s) for which the employee is seeking FMLA leave. Your answers should be your **best estimate** based upon your medical knowledge, experience, and examination of the patient. **After completing Part A, complete Part B to provide information about the amount of leave needed.** Note: For FMLA purposes, "incapacity" means the inability to work, attend school, or perform regular daily activities due to the condition, treatment of the condition, or recovery from the condition. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b).

(1) State the approximate date the condition started or will start: _____ *(mm/dd/yyyy)*

(2) Provide your **best estimate** of how long the condition lasted or will last: _____

(3) Check the box(es) for the questions below, as applicable. For all box(es) checked, the amount of leave needed must be provided in Part B.

☐ **Inpatient Care**: The patient (☐ has been / ☐ is expected to be) admitted for an overnight stay in a hospital, hospice, or residential medical care facility on the following date(s): _____

☐ **Incapacity plus Treatment**: *(e.g. outpatient surgery, strep throat)*
Due to the condition, the patient (☐ has been / ☐ is expected to be) incapacitated for *more than* three consecutive, full calendar days from _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)*.

The patient (☐ was / ☐ will be) seen on the following date(s): _____
_____

The condition (☐ has / ☐ has not) also resulted in a course of continuing treatment under the supervision of a health care provider *(e.g. prescription medication (other than over-the-counter) or therapy requiring special equipment)*

☐ **Pregnancy**: The condition is pregnancy. List the expected delivery date: _____ *(mm/dd/yyyy)*.

☐ **Chronic Conditions**: *(e.g. asthma, migraine headaches)* Due to the condition, it is medically necessary for the patient to have treatment visits at least twice per year.

☐ **Permanent or Long Term Conditions**: *(e.g. Alzheimer's, terminal stages of cancer)* Due to the condition, incapacity is permanent or long term and requires the continuing supervision of a health care provider (even if active treatment is not being provided).

☐ **Conditions requiring Multiple Treatments**: (*e.g. chemotherapy treatments, restorative surgery)* Due to the condition, it is medically necessary for the patient to receive multiple treatments.

☐ **None of the above**: If none of the above condition(s) were checked, (i.e., inpatient care, pregnancy) no additional information is needed. Go to page 4 to sign and date the form.

Employee Name: _____

(4) If needed, briefly describe other appropriate medical facts related to the condition(s) for which the employee seeks FMLA leave. *(e.g., use of nebulizer, dialysis*) _____

_____

PART B: Amount of Leave Needed

For the medical condition(s) checked in Part A, complete all that apply. 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.

(5) Due to the condition, the patient (☐ had / ☐ will have) **planned medical treatment(s)** (scheduled medical visits) *(e.g. psychotherapy, prenatal appointments)* on the following date(s): _____

_____

(6) Due to the condition, the patient (☐ was / ☐ will be) **referred to other health care provider(s)** for evaluation or treatment(s).

State the nature of such treatments: *(e.g. cardiologist, physical therapy)* _____

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the treatment(s).

Provide your **best estimate** of the duration of the treatment(s), including any period(s) of recovery *(e.g. 3 days/week)*

_____

(7) Due to the condition, it is medically necessary for the employee to work a **reduced schedule**.

Provide your **best estimate** of the reduced schedule the employee is able to work. From _____ *(mm/dd/yyyy)* to _____ *(mm/dd/yyyy)* the employee is able to work: *(e.g., 5 hours/day, up to 25 hours a week)*

_____

(8) Due to the condition, the patient (☐ was / ☐ will be) **incapacitated for a continuous period of time**, including any time for treatment(s) and/or recovery.

Provide your **best estimate** of the beginning date _____ *(mm/dd/yyyy)* and end date _____ *(mm/dd/yyyy)* for the period of incapacity.

(9) Due to the condition, it (☐ was / ☐ is / ☐ will be) medically necessary for the employee to be absent from work on an **intermittent basis** (periodically), including for any episodes of incapacity i.e., episodic flare-ups. Provide your **best estimate** of how often (frequency) and how long (duration) the episodes of incapacity will likely last.

Over the next 6 months, episodes of incapacity are estimated to occur _____ times per (☐ day / ☐ week / ☐ month) and are likely to last approximately _____ (☐ hours / ☐ days) per episode.

Employee Name: _____

PART C: Essential Job Functions

If provided, the information in Section I question #4 may be used to answer this question. If the employer fails to provide a statement of the employee's essential functions or a job description, answer these questions based upon the employee's own description of the essential job functions. An employee who must be absent from work to receive medical treatment(s), such as scheduled medical visits, for a serious health condition is considered to be *not able* to perform the essential job functions of the position during the absence for treatment(s).

(10) Due to the condition, the employee (☐ was not able / ☐ is not able / ☐ will not be able) to perform *one or more* of the essential job function(s). Identify at least one essential job function the employee is not able to perform:

_____

_____

Signature of Health Care Provider _____ **Date** _____ *(mm/dd/yyyy)*

Definitions of a Serious Health Condition *(See 29 C.F.R. §§ 825.113-.115)*
Inpatient Care
• An overnight stay in a hospital, hospice, or residential medical care facility. • Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.
Continuing Treatment by a Health Care Provider (any one or more of the following)
Incapacity Plus Treatment: A period of incapacity of more than three consecutive, full calendar days, and any subsequent treatment or period of incapacity relating to the same condition, that also involves either: o Two or more in-person visits to a health care provider for treatment within 30 days of the first day of incapacity unless extenuating circumstances exist. The first visit must be within seven days of the first day of incapacity; or, o At least one in-person visit to a health care provider for treatment within seven days of the first day of incapacity, which results in a regimen of continuing treatment under the supervision of the health care provider. For example, the health provider might prescribe a course of prescription medication or therapy requiring special equipment.
Pregnancy: Any period of incapacity due to pregnancy or for prenatal care.
Chronic Conditions: Any period of incapacity due to or treatment for a chronic serious health condition, such as diabetes, asthma, migraine headaches. A chronic serious health condition is one which requires visits to a health care provider (or nurse supervised by the provider) at least twice a year and recurs over an extended period of time. A chronic condition may cause episodic rather than a continuing period of incapacity.
Permanent or Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, but which requires the continuing supervision of a health care provider, such as Alzheimer's disease or the terminal stages of cancer.
Conditions Requiring Multiple Treatments: Restorative surgery after an accident or other injury; or, a condition that would likely result in a period of incapacity of more than three consecutive, full calendar days if the patient did not receive the treatment.

DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR. RETURN TO THE PATIENT.

RELEASE TO RETURN TO WORK

COMPLETED FORMS CAN BE RETURNED IN-PERSON, MAIL OR VIA FAX (314) 244-1739

Your "**Release to Return to work**" document must be submitted to the Human Resources Division, if at all possible, at least two weeks (14 days) prior to the indicated return date.

PLEASE PRINT:

Today's Date: _____ Employee Number: _____

Employee Name: _____ Location/Position: _____

Leave Start Date: _____ Date of Return to Work: _____

Employee Signature _____

Date _____

==========

IF RETURNING FROM FMLA OR OTHER LEAVE THAT IS MEDICALLY RELATED

To be completed by Health Care Provider:

I hereby certify that (patient's name) _____ was under my professional care for (nature of injury or illness)_____

_____

For the period beginning _____and ending _____.

I further certify that he/she is free from any communicable disease and that he/she is physically and mentally capable of performing his/her full duties as a teacher/employee, effective _____.

Name of Health Care Provider (Print):_____

Signature of Health Care Provider _____ **Mailing Address** _____

_____

Type of Practice (Field of Specialization, if any) _____ _____

Date _____

LEAVE OF ABSENCE PROCESS

Request for leave must be made at least thirty (30) days prior to the date the requested leave is to begin, or as soon as practicable under the circumstances:

1) The employee must complete the appropriate "Request for Leave of Absence" form. Please refer to the following for specific documentation required depending on which type of leave is being requested. ***Please note, all leave types require the completion of an application for leave and any other related forms for the specified leave of absence.***

   Education Leave: The institution of higher education must be identified and proof of acceptance for study at the institution must be provided. A list of courses to be taken and the degree sought, if any, must be included in the detailed plan. ***An employee can remain on this type of leave for up to one year, not to exceed one year.***

   Sabbatical Leave: If the request is for travel, a detailed analysis of the travel experience planned must be provided, which includes sites to be visited, purpose and anticipated dates of visits. Upon return, a synopsis will be required of how the travel benefited the St. Louis Public School District. If the request is for study, the institution of higher education must be identified and proof of acceptance for study at the institution must be provided. A list of courses to be taken and the degree sought, if any, must be included in the detailed plan. If the request is for a combination of study and travel, the applicant must comply with all the aforementioned items. ***An employee can remain on this type of leave for up to one year, not to exceed one year.***

   Military Leave: Orders/Amended Orders required. ***An employee can remain on this type of leave for up to 5 years, not to exceed 5 years.***

   FMLA Leave: Upon receipt of the Request for FMLA Leave of Absence Form, the employee shall be provided a Notice of Eligibility and Rights & Responsibilities Form; Human Resources will first complete Part A - Notice of Eligibility. At that same time, the employee shall also be given the medical certification form -- Certification of Healthcare Provider for Employee's Serious Health Condition or Certification of Healthcare Provider for Family Member's Serious Health Condition, as appropriate. The employee will be expected to return the completed medical certification form within fifteen (15) calendar days. ***Failure to provide the required 15 calendar days notice may result in leave request being denied***. Specific dates (start date and estimated return date) must be provided. Statements such as "until further notice", "undetermined" or "until next appointment" will not be accepted. If the medical certification is incomplete or insufficient, Human Resources will notify the employee in writing of such, stating what information is needed. The employee will provide the additional information within seven (7) calendar days, whenever practicable. Within five (5) business days of receiving sufficient information to make a designation determination, Human Resources will provide the employee with a Designation Notice. ***An employee can remain on this type of leave for up to one year, not to exceed one year (note, this limitation does not apply to intermittent leave or FMLA leave to care for an immediate family member)***

   To be eligible for FMLA, an employee must have been employed by St Louis Public School District ("SLPS") at least twelve (12) months and has worked at least twelve hundred fifty (1,250) hours in the twelve (12) months preceding start of leave*

   Other types of Leave, including Non-FMLA Eligible Medical Leave: Documentation verifying need is required. If for a medically related reason (and the leave does not qualify as FMLA leave), medical certification is required. The medical certification must include the date on which the condition began; the probable duration of the condition, the diagnosis and expected course of treatment; a statement that the employee is unable to perform the essential functions of his/her job. Failing to provide medical certification will result in a delay of leave until such certification is obtained or denial of leave if no certification is provided. Further, the employee will be required to present medical certification of their "fitness-for-duty" to return to work, following the period of leave. ***An employee can remain on this type of leave for up to one year, not to exceed one year.***

2) Once the documents are complete, applicable forms are submitted to Human Resources either in-person, mail or fax (314) 244-1739. The supervisor will be notified of the approved leave request.

3) After the documents are presented to HR **and if** the employee qualifies for STD/LTD benefits, he/she should call the Cigna Insurance Company at (1-800-362-4462) to initiate a new claim **(filing the leave papers 30 days in advance will eliminate there being breaks between pay cycles from SLPS and Cigna Insurance)**

4) Approximately **two weeks (14 days)** prior to his/her return to work, the employee should present to HR a "Release to Return to Work" form, which has been completed by the employee and his/her physician. This document can be submitted to Human Resources either in-person, mail or via fax (314) 244-1739. The employee should not return to work until he/she receives contact from HR stating "authorized to return to work". Supervisors are notified of return from leave dates.

****The employee will be responsible for payment of his/her portion of the benefit premiums****

General Conditions for Leave of Absence

Leave Under the Family and Medical Leave Act ("FMLA")

- The employee has been employed by the St. Louis Public School District ("SLPS") at least twelve (12) months and has worked at least twelve hundred and fifty (1,250) hours in the twelve (12) months preceding start of the leave.
- **An employee, with Special Administrative Board ("SAB") approval, can remain on this type of leave for up to one year, not to exceed one year** (note, this limitation does not apply to intermittent leave or FMLA leave to care for an immediate family member)**.**
- The employee is aware that FMLA Leave runs concurrently with short-term disability, sick leave, paid time off and/or vacation.
- If eligible for short-term disability, the first thirty (30) days are considered a "waiting period" and the employee will have the option to elect to use accrued time to be paid for those days or take that time without pay.
- The employee is aware that a leave request for his/her own serious health condition or the serious health condition of a family member cannot be approved without the Special Administrative Board ("SAB") receiving a fully completed medical certification from a health care provider.
- If the employee does not return to work or contact Human Resources, per the expected return to work date indicated on the leave paperwork, it will be considered that the employee has voluntarily terminated employment with the SLPS.
- The SAB can recover employer premiums paid to continue the employee's health insurance coverage if they fail to return to work after leave, unless failure to return is because of (1) continuation, recurrence, or onset of a serious health condition, either of the employee or a family member; or (2) other circumstances beyond the employee's control.

Education Leave

(Short-term education leave – 5 days or less)

- The process is managed by the direct supervisor and documentation is kept at the school site.
- Leave is ***with pay*** for the purpose of attending workshops, conferences, conventions, seminars and visitations conducive to the employee's personal growth.

(Long-term education leave – 6 days to 1 year)

- The process is managed by Human Resources and documentation is submitted to Human Resources for processing.
- Leave is ***without pay and benefits*** for the purpose of study for professional improvement.
- Employee must be enrolled for a minimum of eight (8) approved college semester hours per semester of leave.
- The extent of leave shall not exceed the time-frame of the scheduled work year for the employee.
- Employee is required to submit an official transcript, within 30 days of returning from leave, reflecting successful completion of the required minimum of eight (8) semester hours of college credit earned during each semester of leave.

Military Leave

- Leave is granted for emergency military duty, tours of duty, reserve training and time off for physical exams for military duty.
- Emergency duty leave is with pay for up to 30 days during the school/fiscal year in which the leave begins.
- Time will be unpaid unless employee elects to use previously accrued time.
- All full-time employees who are members of the National Guard or of any reserve component of the Armed Forces of the United States shall be granted leave with regular pay for the period not to exceed a total of fifteen (15) work days in any fiscal year for reserve training.

Other (including Non-FMLA Eligible Medical Leave)

- If eligible for short-term disability, the first thirty (30) days are considered a "waiting period" and the employee will have the option to elect to use accrued time to be paid for those days or take time without pay.
- Short-term disability is for a maximum of 180 calendar days or the equivalent of 6 months.
- The employee may be eligible to apply for Long-term disability.
- The employee is aware that a leave request for own serious health condition cannot be approved without the SAB receiving documentation from the treating physician sufficient to determine the reasonableness and appropriateness of the requested leave.
- If the employee does not return to work or contact Human Resources, per the expected return to work date indicated on the leave paperwork, it will be considered that the employee has voluntarily terminated employment with the SLPS.
- The SAB can recover employer premiums paid to continue the employee's health insurance coverage if they fail to return to work after leave, unless failure to return is because of (1) continuation, recurrence, or onset of a serious health condition; or (2) other circumstances beyond the employee's control.

Sabbatical Leave

- To be eligible for this leave, an employee shall have been employed nine (9) consecutive school years as a full-time employee of the SLPS, unless otherwise specified by the district.
- The leave is for the purpose of professional improvement.
- Employee shall receive one-half of his/her scheduled salary during the period of this leave.
- The leave shall not prevent the advancement on the salary schedule nor constitute a break in consecutive years of employment.
- Leave requests for first semester of each school year must be filed with Human Resources no later than March 15th of previous school/fiscal year.
- Leave requests for second semester must be filed with Human Resources no later than November 15th of current school/fiscal year.
- Employee will earn a minimum of eight (8) semester hours of college credit during **each** semester of the leave for study, exclusive of summer, and submit to Human Resources an official transcript immediately following the end of each semester of approved leave.
- Upon return from sabbatical leave for travel, employee is required to submit a comprehensive report providing analysis of travel experiences and of how the travel benefited the SLPS, depending if the leave was taken for study, travel or combination of both study and travel.

*** The employee will be responsible for payment of his/her portion of the benefit premiums***

Q&A

LEAVE OF ABSENCE

Q: **How soon should I submit paperwork for a leave of absence?**
*A: Approximately 30 days prior (**not** greater than 30 days), or as soon as possible, to taking leave*

Q: **What types of Leaves are available to me / what paperwork is required / what is the eligibility period, if applicable?**
A: ***Education Leave:***
Documents Required: Leave Application, Proof of acceptance for study, list of courses to take and degree sought

Sabbatical Leave:
Documents Required: Leave Application

*(**for travel**) detailed analysis of travel experience planned, to include sites to be visited/purpose and anticipated dates of visit*

*(**for study**) proof of acceptance for study, list of courses to take and degree sought*

*(**combination of travel & study**) must comply with above items*

**To be eligible for Sabbatical, an employee shall have been employed nine (9) consecutive school years as a full-time employee of the SLPS, unless otherwise specified by the district*

Military Leave:
Documents Required: Leave Application, Orders/Amended Orders

FMLA Leave:
Documents Required: Leave Application, Certification of Healthcare Provider

To be eligible for FMLA, an employee must have been employed by St Louis Public School District ("SLPS") at least twelve (12) months and has worked at least twelve hundred fifty (1,250) hours in the twelve (12) months preceding start of leave

Other types of Leave, including Non-FMLA Eligible Medical Leave:
Documentation Required: Leave Application, Certification of Healthcare Provider (if leave is for medical reasons), any documentation verifying need

Q: **Where can I locate the leave of absence paperwork?**
A: **Intranet**: Human Resources Tab > HR Document Library
Outlook: Public Folders > All Public Folders > Human Resources > HR Forms > Leave of Absence
Human Resources: in-person at front reception area in Human Resources
you can request a copy of the appropriate leave of absence paperwork to be emailed/mailed to you

Q: **What happens once I submit the required paperwork for Leave?**
A: *Your application/paperwork will be reviewed by HR and you will be notified of eligibility & approval*

Q: **When should I submit my Release to Return to Work form?**
A: *Approximately two weeks (14 days) prior to your return to work or as soon as possible prior to the return date*

Q: **How long can I remain on a leave of absence?**
A: *An employee, with Special Administrative Board ("SAB") approval, can remain on a leave for up to one year, not to exceed one year, based on the type of leave of absence being requested*

Q: **Are Leaves paid or unpaid?**
A: A Leave of Absence is unpaid, unless:

- *The employee has an accrued sick bank / PTO bank and wants to use this time*
- *The employee is eligible for short-term disability (no sick bank remaining) *must contact Cigna directly to initiate a claim (800-362-4462)*

CONSECUTIVE FMLA LEAVE VERSUS INTERMITTENT FMLA LEAVE

GENERAL INFORMATION

The **Family and Medical Leave Act of 1993** (**FMLA**) is a United States federal law requiring covered employers to provide employees job-protected unpaid leave for qualified medical and family reasons. These reasons include personal or family illness, military service, family military leave, pregnancy, adoption, or the foster care placement of a child.

CONSECUTIVE FMLA LEAVE

Employee is eligible for FMLA if they have worked the previous 12 months or a minimum of 1,250 hours

FMLA Leave can be taken for the employee's own serious health condition or to care for an immediate family member

FMLA is generally the ***first 12 weeks*** of a Leave of Absence. FMLA runs ***concurrently with a Medical Leave***

Employee ***does not*** work during FMLA/Medical Leave of Absence

Employee uses time from accrued bank (PTO, Vacation, Sick – if applicable)

An approved Leave of Absence will be managed by Human Resources

Short-Term Disability does not apply to Leave of Absence for care of an immediate family member

Employee can apply for Short-Term Disability (if eligible) for own serious Health condition leave of absence

INTERMITTENT FMLA LEAVE

Employee is eligible for FMLA if they have worked the previous 12 months or a minimum of 1,250 hours

FMLA Leave can be taken for the employee's own serious health condition or to care for an immediate family member

FMLA is in place for a maximum of 12 weeks of Leave of Absence in a 12 month rolling period. FMLA can be taken in day and hour increments, based on the circumstances for leave of absence

Employee ***works on a reduced schedule*** (days and hours will vary) during FMLA/Medical Leave of Absence

Employee uses time from accrued bank (PTO, Vacation, Sick – if applicable)

Once Intermittent Leave of Absence is approved by Human Resources, the Employee is responsible for submitting specific dates/hours to Human Resources for tracking FMLA time only. Employee is still responsible for communicating absences and how to code absences (i.e. PTO, absence without pay, etc) to the direct supervisor and appropriate time-keeper

Short-Term Disability does not apply to Intermittent Leave of Absence

SICK LEAVE BANK AND TAKING A LEAVE OF ABSENCE

GENERAL INFORMATION

If an employee opted to keep his/her sick leave bank under Option 2

- Your sick leave bank balance is available for sick days until exhausted
- You will be covered by the STD/LTD plans upon first day actively at work in the academic year ***following*** exhaustion of your sick leave bank
- When you become eligible for LTD coverage, you will be subject to the insurance company's "pre-existing" condition restrictions, meaning disability benefits may not be paid for a disability caused by a condition that exists when you become eligible
- The Board will report the days that remain in your sick leave bank at retirement to the Retirement System for retirement benefit **eligibility** purposes (only)

SHORT-TERM DISABILITY / LONG-TERM DISABILITY

GENERAL INFORMATION

SHORT-TERM DISABILITY

***Initiated by employee**

Eligibility Period
After 90 days of active service

Waiting Period
(First 30 days of leave is the waiting period)
30 work days before coverage begins

Coverage
60% of base pay
Paid Weekly

Coverage Time-Frame
Up to and including 6 months or 180 days

LONG-TERM DISABILITY

***initiated by Cigna Insurance 30 days prior to end of STD period**

Eligibility Period
After 90 days of active service

Waiting Period
N/A

Coverage
60% of base pay
Paid Monthly

Coverage Time-Frame
(Coverage begins)
The latter of 180 days or the end of the STD period

(Coverage ends)
When you are released by your physician and/or reach
Your legal retirement age

Once all required documentation has been received by Human Resources **and if** the employee qualifies for STD/LTD benefits, he/she should call the Cigna Insurance Company at (1-800-362-4462) to initiate a new claim **(filing the leave papers 30 days in advance will eliminate there being breaks between pay cycles from SLPS and Cigna Insurance)**

When initiating a claim, employee should indicate they are an employee of "The Board of Education, City of Saint Louis"

How to report a

DISABILITY CLAIM

under The Board of Education of the City of St. Louis's group disability insurance plan

How do I report a disability claim?

Simply do one of the following:

- Call toll-free at **1.800.36.Cigna (24462)** or **1.866.562.8421** (Español). A representative will walk you through the process.
- Fill out a claim form online at **Cigna.com/customer-forms**.

When do I report a claim?

- Contact your employer on or before your first day out of work. Tell them when and for how long you plan to be absent.
- If you know you'll be out for more than 30 calendar days in a row, call Cigna at **1.800.36.Cigna (362.4462)**. Make sure you call us before your thirtieth (30th) calendar day out of work so we can begin reviewing your claim.

What information do I need?

Before you call or go online, please have this information handy:

- Your name, address, phone number, birth date, Social Security number and email address.
- Employment information, such as date hired and job title.
- Reason for your claim – illness, injury or pregnancy.
- Description of your illness, symptoms, and/or diagnosis. Include the date your symptoms started and if you have had these symptoms before.
- Workers' compensation claims you've filed or plan to file.
- Details about doctor, hospital or clinic visits, including dates and contact information.

What happens next?

During the call, we'll ask for your permission to get your medical information. Here's how it works:

- After you give us your claim information, you'll be transferred to a recorded message.
- Listen to the recording and answer "Yes" or "No" to the questions.
- At the end of the recording, say "Yes" if you give permission or "No" if you do not.
- You can cancel your permission at any time by calling your Cigna claim manager.

After the call, Cigna will send you a letter. It'll include a copy of the recorded message for your records. It'll also include a form that gives us permission to get other information we may need to finish processing your claim. Please sign and return that form. Check with your doctor to see if there are any other forms you need to sign.

A Cigna claim manager will call you and your employer for a list of your job requirements. The claim manager will also call your doctor for your medical records. This information will help us figure out how long you may be out of work, and the benefits you may be able to receive.

What happens if my claim is approved?

- Cigna will send you an approval letter that gives you an explanation of your benefits. You may also get a recorded call from Cigna with this information.
- Cigna will coordinate payment of your benefits as soon as possible.
- Cigna will tell your employer that we approved your claim, and the date you plan to return to work.

If you need immediate medical attention, please call 911

Cut and carry for easy reference

How to report a disability claim
1.800.36.Cigna (24462) or 1.866.562.8421 (Español)
Visit: Cigna.com/customer-forms

Please have this information handy:

- Your name, address, phone number, birth date, date of hire, Social Security number and your employer's name, address and phone number.
- Date of your claim and when you plan to return to work. If you're pregnant, give your expected delivery date.
- Name, address and phone number of each doctor you are seeing for this absence.

GO YOU

What happens if my claim is denied?

- Cigna will send you a letter that explains why. The letter will also tell you how you can appeal the decision.
- Cigna will let your employer know the claim is denied.
- You should call your employer when you get the letter to discuss your return-to-work date.

What can I expect while I'm out?

Your Cigna claim manager will stay in touch to help you return to work quickly and safely. We may work with you, your doctor and your employer to talk about different work options. This may include an adjustment to your job or work schedule. Your employer may also call you to check on your progress and offer support.

What if I can't return to work on the date my disability benefits end?

- Call your Cigna claim manager to talk about the situation and learn about your options.
- Let your employer know your progress and status.

What should I do when it's time to return to work?

Call your employer and Cigna claim manager to let them know the date you'll be returning to work.

Questions?

Call **1.800.36.Cigna (24462)**. A Cigna representative is available to help you between 7:00 am and 7:00 pm CST.

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