



## LEAVE OF ABSENCE REQUEST INSTRUCTIONS

*(Leave Types: Medical, Parental/Adoption/Foster Care, Family Care, Educational and Military LOA)*

If you have an assault leave request, contact the LOA Specialist at 216.838.0054.

LOA requests must be submitted via Workday, thirty (30) calendar days in advance when the need for leave is foreseeable.

All work related leave are subject to approval through Workers Comp.

**INTERMITTENT LEAVE REQUESTS: An eligible employee who needs intermittent leave or leave on a reduced leave schedule for a qualifying reason, needs to be foreseeable based on planned medical treatment and not exceed 20 percent of the total number of working days over the period the leave would extend.**

### **How to submit your LOA Request via Workday:**

1. Scan your paperwork for your records and preparation for upload to Workday.
2. Log into Workday and click the time off icon.
3. Select the Leave of Absence tab.
4. Enter the estimated dates for your leave starting with the \*First Day of Leave Option.
5. Choose your leave type.
6. Upload your scanned paperwork under "Attachments".
7. Hit the Submit button and follow the additional prompts in your Workday Inbox.

*You will receive notification of determination within three (3) to five (5) business days upon receipt of your request.*

\*If a sub is required for your absence it is the responsibility of the employee to enter the absence in the CMSD Sub Center. If assistance is needed please contact Diane Hlavaty at 216.838.0069 or via email at [substitutes@clevelandmetroschools.org](mailto:substitutes@clevelandmetroschools.org).

### **How to submit a Return to Work request via Workday:**

1. If Applicable scan your paperwork for your records and preparation for the upload to Workday.
2. Log into Workday and click the time off icon.
3. Select the Return to Work tab.
4. Enter your last day of leave.
5. Upload your scanned paperwork under "Attachments".

All return to work requests should be submitted 2 weeks, prior to expiration of your leave of absence.

No Documentation is required for return from: parental, family care, or intermittent leave.

Return to work requests with restrictions require prior approval from the LOA department.

For additional assistance; please contact The Employee Relations Department via email at [employeerelations@clevelandmetroschools.org](mailto:employeerelations@clevelandmetroschools.org)

# EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

## LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;\* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

\*Special "hours of service" requirements apply to airline flight crew employees.

## BENEFITS & PROTECTIONS

## ELIGIBILITY REQUIREMENTS

## REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

## EMPLOYER RESPONSIBILITIES

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

## ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.



For additional information or to file a complaint:

# 1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

## www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division



**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**



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](http://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: Cleveland Metropolitan School District 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:

\_\_\_\_\_  
\_\_\_\_\_

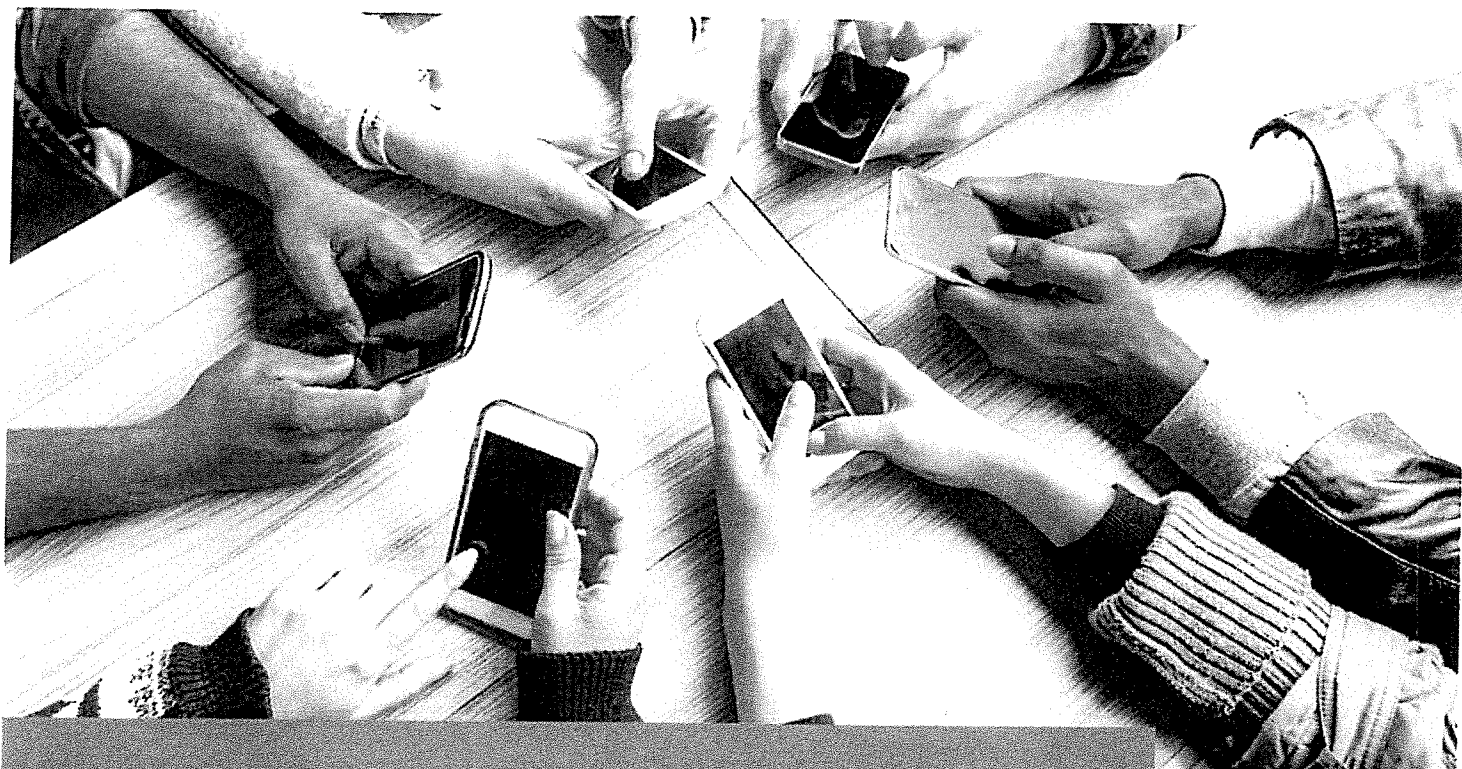
Signature of  
Health Care Provider \_\_\_\_\_ Date \_\_\_\_\_ (mm/dd/yyyy)

Definitions of a Serious Health Condition (See 29 C.F.R. §§ 825.113-.115)
<b>Inpatient Care</b>
<ul style="list-style-type: none"><li>• An overnight stay in a hospital, hospice, or residential medical care facility.</li><li>• Inpatient care includes any period of incapacity or any subsequent treatment in connection with the overnight stay.</li></ul>
<b>Continuing Treatment by a Health Care Provider (any one or more of the following)</b>
<b><u>Incapacity Plus Treatment:</u></b> 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: <ul style="list-style-type: none"><li>○ 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,</li><li>○ 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.</li></ul>
<b><u>Pregnancy:</u></b> Any period of incapacity due to pregnancy or for prenatal care.
<b><u>Chronic Conditions:</u></b> 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.
<b><u>Permanent or Long-term Conditions:</u></b> 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.
<b><u>Conditions Requiring Multiple Treatments:</u></b> 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.

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 15 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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



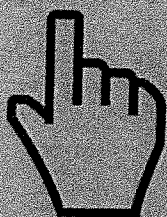
EASE@WORK PRESENTS:

# MY LIFE EXPERT

**CHANGING THE  
GAME IN  
EMPLOYEE  
WELLNESS**





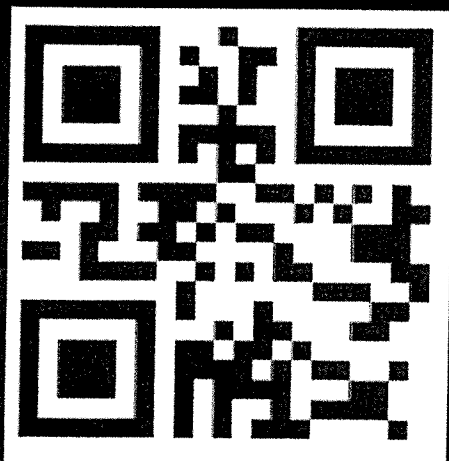
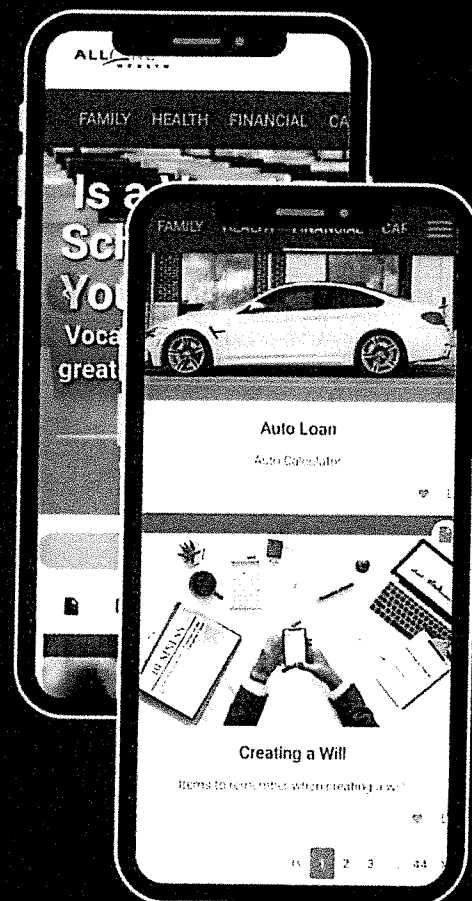


# WORK/LIFE BALANCE AT YOUR FINGERTIPS

## MY LIFE EXPERT ALLOWS YOU ACCESS TO:

- THOUSANDS of articles, videos, and worksheets
- Quick Health and Lifestyle assessments and surveys
- Interactive checklists
- Events Calendar for the latest webinars and online training sessions
- Your company's HR info and company-wide alerts
- Build your own Employee Profile
- 24/7 instant, confidential support

**TO LOGIN, USE YOUR COMPANY CODE:**  
**cmsdist**



**ACCESS YOUR FULL EAP BY CALLING:**  
**1-800-521-3273,**  
**DOWNLOADING THE APP BY**  
**VISITING: [WWW.MYLIFEEXPERT.COM](http://WWW.MYLIFEEXPERT.COM)**  
**OR**  
**SIMPLY SCAN THIS QR CODE**



**EASE@WORK**

An AllOne Health Company



# EMPLOYEE ASSISTANCE PROGRAM

Financial worries, aging parents, job stress, health issues - Everyone faces challenges from time to time, with your EAP you don't have to face these things alone.

*This includes solutions such as:*

ANYTIME, ANYWHERE

Reducing barriers to access through technology  
**INCLUDES: 24/7/365 Telephone Support,  
Mobile App with Chat Functionality, Video  
Counseling and Web Portal**

## PERSONAL ASSISTANT

Our Personal Assistant helps individuals with their "to do" list. It can be difficult to find extra time in the day to manage everyday tasks. We help lighten the load through researching the best options to benefit you and your loved ones.

**SERVICES INCLUDE: Entertainment & Dining,  
Travel & Tourism, Household Errands, Service  
Professionals**

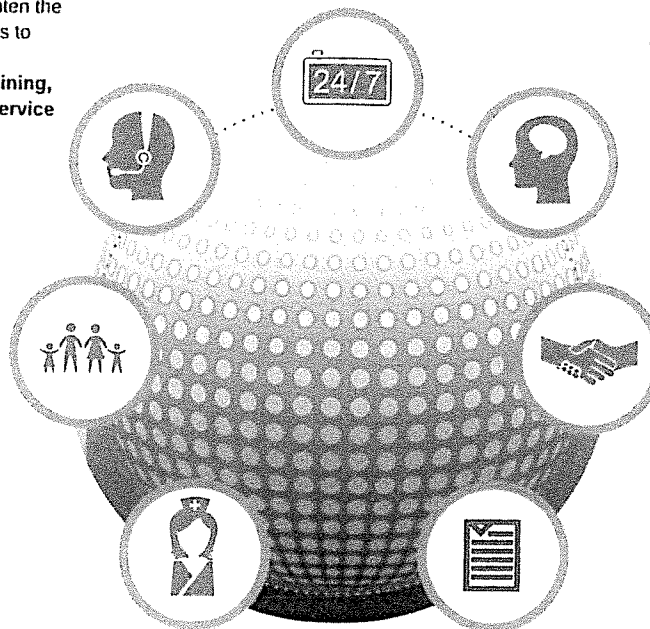
## MENTAL HEALTH COUNSELING

When overwhelmed with personal, work or life stressors, mental health counseling can be a lifesaver. Our licensed master's level counselors support you and your household members through difficult times providing confidential assistance 24/7.

**WE HELP WITH: Family Conflict,  
Couples/Relationships, Substance Abuse,  
Anxiety, Depression**

## COACHING

We help employees and their household members meet their personal and professional goals by offering Life Coaching as Well as Wellness Coaching. A coach works actively to help individuals assess their current situation then develop goals to meet their stated expectations. A coach is an accountability partner and helps individuals overcome obstacles to achieve goals. **LIFE COACHES HELP WITH: Life Transitions, Work/Life Balance, Goal Setting, Improving Relationships** **WELLNESS COACHES HELP WITH: Nutrition, Fitness, Stress Reduction & Tobacco Cessation**



## WORK/LIFE RESOURCES

Navigating the practical challenges of life, while handling the demands of your job can be stressful. Work/Life resources and referral services are designed to provide knowledgeable consultation and customized guidance to assist with gaining resolution to everyday hurdles.

**RESOURCES INCLUDE: Adoption,  
Elder/Adult Care, Parenting, Child  
Care, Special Needs Support,  
Wellness**

## MEDICAL ADVOCACY

Medical Advocacy is a new approach to maneuvering through the healthcare system. It offers strategies to promote employee health, productivity, and well-being by serving patient populations throughout the entire lifespan and by addressing health problems in every category of disease classification and in all disease stages.

**WE HELP WITH: Insurance Navigation, Doctor Referrals, Specialist Referrals, Care Transition, Discharge Planning, Adult Care Coach**

## LEGAL/FINANCIAL RESOURCES

Legal and Financial resources and referrals are available to connect employees with experienced, vetted professionals in their topical area of legal and financial needs.

**RESOURCES INCLUDE: Divorce/Custody, Bankruptcy,  
Budgeting, Estate Planning/Wills, Personal Injury/Malpractice,  
Major Life Event Planning**

## **PRIVATE, CONFIDENTIAL & FREE** FOR YOU AND YOUR HOUSEHOLD MEMBERS

Your participation with your EAP is voluntary and strictly confidential. We do not report back to your employer about the things you discuss in private counseling conversations.

## MY LIFE EXPERT

*Feeling Connected & Supported 24/7-365*

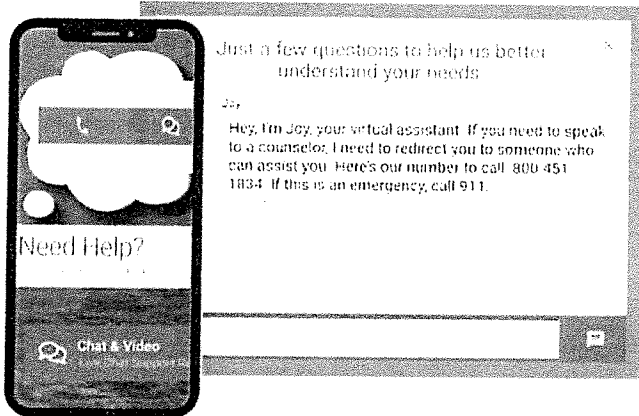
You can download the app to the home screen of your mobile device without even visiting an app store, by simply visiting [mylifeexpert.com](http://mylifeexpert.com) or scanning the QR code at the bottom of this page.

### TO LOGIN:

- Click "create a new account with your company code"
- Insert your company access code
- Follow instructions included in the activation e-mail
- Play, learn, and discover!

### LIVE COUNSELING:

Download the Life Expert app for 24/7 connectivity to live counselors. This functionality includes live access to a counselor via chat, video, and toll-free phone support.



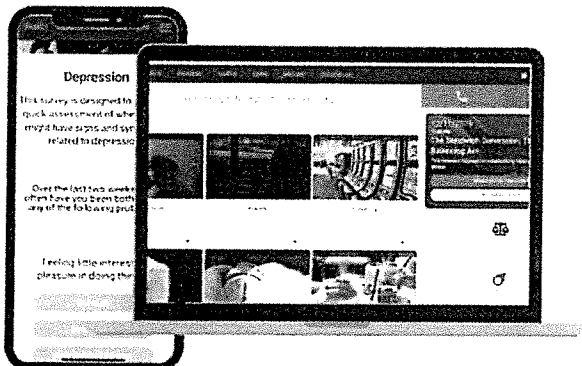
### WORK & LIFE RESOURCES:

Life Expert provides access to thousands of up-to-date topic-related articles, videos and worksheets. Some topics include: Financial & Legal, Family, Education, Health, Wellness, Career, Military, everyday living and much more.



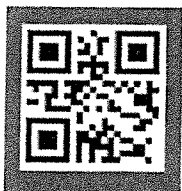
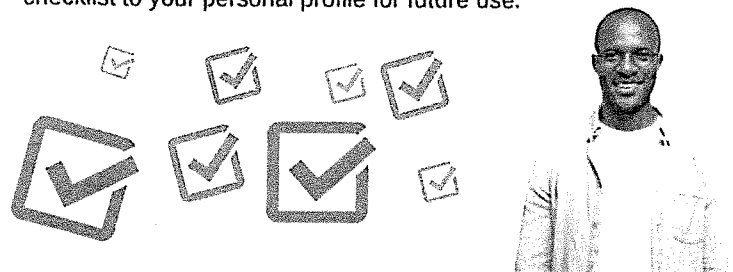
### HEALTH & LIFESTYLE ASSESSMENTS:

Surveys are provided to you with a quick assessment on financial, health and addiction issues. These surveys are designed to deliver targeted resources and information to meet your needs. You can save these assessments and recommendations to your profile for future use.



### INTERACTIVE CHECKLIST:

Life Expert provides you with interactive tools to help with issues such as family, health, and other life situations. You can save these checklist to your personal profile for future use.



**Download The App at : [mylifeexpert.com](http://mylifeexpert.com)**

**Company Access Code:** cmsdist

**Toll-Free:** 800-521-3273

**EASE@WORK**