

Compensation and Human Resources Planning
LEAVE
OF
ABSENCE

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Leave of Absence

A leave of absence is permission granted by the Board, or allowed under its adopted policies, for an employee to be absent from duty for specific periods of time with the right of returning to employment on the expiration of the leave.

When to Apply for an Unpaid Leave of Absence

A leave of absence is required whenever an employee is out for more than 10 consecutive unpaid days.

Leaves employees may be eligible for:

CTA	AESOP	FPSU
<ul style="list-style-type: none"> •Sick Leave for Self •Sick Leave to care for Family member •Maternity/Child Care •Career Change •Military •Political •Sabbatical (1/2 paid) •Personal (case by case basis) •CTA Sick Bank Paid Leave •Catastrophic Sick Paid Leave 	<ul style="list-style-type: none"> •Sick Leave for Self •Sick Leave to care for Family Member •Maternity /Child Care •Military •Personal (case by case basis) •Personal (student teaching) •Political •Catastrophic Sick Paid Leave 	<ul style="list-style-type: none"> •Personal Sick •Personal Sick to care for a family member •Personal •Maternity/Child Care •Political •Catastrophic Sick Paid Leave

Determine Type of Leave


1. Determine the type of leave needed by reviewing the different leave options. You can use our short cut above or visit our leave web page at www.palmbeach.k12.fl.us/jobs/Compensation/Leaves.htm
2. Once leave has been determined print out the required leave forms and have employee complete them.

		<h2 style="color: white; background-color: #0056b3; padding: 5px;">COMPENSATION & HR PLANNING</h2>	
Compensation Home --- Leaves --- Retirement --- Resignation --- FAQ's --- Helpful Numbers --- Contact Us			
Administrative Staff <ul style="list-style-type: none"> • Principals' Tips • Manuals • Breeze Presentation 	<h3 style="color: #0056b3;">LEAVE OF ABSENCES</h3> <p>A leave of absence is permission granted by the Board, or allowed under its adopted policies, for an employee to be absent from duty for specific periods of time with the right of returning to employment on the expiration of the leave.</p> <p>When applying for a leave of absence, employees must fill out district-approved leave request forms. When an employee is absent from work, the employee must be on an approved leave (i.e., using sick or vacation hours, a School Board approved leave, etc.). If the employee is out using sick/vacation time or is out 10 days or less consecutively, they process their TDE through their job site. If the employee is out more than 10 unpaid days consecutively, the employee will have to apply for an unpaid leave of absence.</p>  <p>For further information please contact:</p> <p style="text-align: center;"> Customer Call Center Toll Free 1-877-477-3722 Local 561-434-8777 OR PX 4-8777 </p> <p style="text-align: center;"> Ernie Camerino, Manager, Leaves & Retirement </p> <p style="text-align: center;"> Annette Arriaga, HR Analyst Senior </p> <p style="text-align: center;"> Juan Diaz , HR Tech III Fax (561) 357-1145 </p>		
Secretaries <ul style="list-style-type: none"> • Manuals • Breeze Presentation 			
General Information for All Employees <ul style="list-style-type: none"> • Sick Leave Q & A • Maternity Leave Q & A • Leave of Absence 			
Deadlines <ul style="list-style-type: none"> • Sabbatical Leave (April 1) • Professional Leave (May 1) • Career Change Leave (May 1) 			
Bargaining Agreements			
Resources <ul style="list-style-type: none"> • PBSD 1666 Application for Unpaid Leave • District Leave Policy 3.80 			
FMLA Information <ul style="list-style-type: none"> • FMLA Overview • PBSD 2312 • PBSD 2313 • PBSD 2314 • PBSD 2315 			

Leave Application

1. Form PBSO 1666 must be completed by employee when applying for an unpaid leave. Please use the following checklist when completing form

- ✓ Employee name and EMPLID
- ✓ Last day worked
- ✓ Last sick/vacation day after last day worked
- ✓ Expected return date, please keep in mind the following:
- ✓ Childcare/Maternity leave returned date is agreed on by the employee and supervisor when between semesters or marking periods.
- ✓ Sick leave expected return date is based on the doctor's recommendation.
- ✓ Leave Type
- ✓ Employee and Principal/Department Head signature
- ❖ If this is a leave extension the following needs to be completed:
- ✓ Section B, revised expected return date
- ✓ Leave Type
- ✓ Employee signature
- ✓ Principal/Department Head signature



THE SCHOOL DISTRICT OF PALM BEACH COUNTY
Request for Leave of Absence Without Pay
 Initial Request Extension

DIRECTION B: If you are submitting this form for an initial leave check "Initial Request" above and complete section A. If you are requesting an extension to an existing leave check "Extension" above and complete section B. Incomplete form will not be approved.
 Leaves of absence (pursuant to School Board Policy 3.50 or collective bargaining agreement) will be approved by the Superintendent's designee prior to the School Board action. If requesting Family Medical Leave Act (FMLA) attach the appropriate FMLA District form (PBSO 2312, 2313, 2314, or 2315).

<small>Name</small>	<small>Social Sec # (last 4 digits only)</small>	<small>Employee ID #</small>
<small>Position</small>	<small>School/Department</small>	

SECTION A - INITIAL REQUEST
 Complete this section if this is your first request for leave without pay.

Date of last day worked _____

Date of last sick day used _____

Initial here if you are choosing not to use sick days (use only when applying for Maternity or Sick Leave)

Expected return date _____

SECTION B - EXTENSION REQUEST
 Complete this section if your purpose is to extend your initial request for leave without pay.

Revised date returning to work _____


TYPE OF LEAVE REQUESTED	DOCUMENTATION REQUIRED
<input type="checkbox"/> Sick Leave <input type="checkbox"/> Self <input type="checkbox"/> Immediate Family Member <input type="checkbox"/> Personal Medical (FPSU/PBA (attach documentation)) <input type="checkbox"/> Workers Compensation	Attach a doctor's statement indicating the medical facts to support the need for the leave and the required time of absence or (if requesting FMLA attach the appropriate FMLA District form (PBSO 2312, 2313, 2314 or 2315).
<input type="checkbox"/> Maternity/Child Care	Attach a doctor's statement indicating the pending date of birth (PBSO 2312 or 2313). Attach a letter indicating date of placement if adoption/ foster care.
<input type="checkbox"/> Personal (includes student teaching) <input type="checkbox"/> Administrative / Non-Instructional <input type="checkbox"/> Long Term Leave CTA (membership not required) <input type="checkbox"/> Personal Non-medical (FPSU/PBA)	Attach a letter from employee outlining the specific need/hardship. Personal Non-medical will be approved by Principal/Department Head.
<input type="checkbox"/> Professional CTA (membership not required)/Non-bargaining	Attach a letter from employee indicating the type of professional activity. Non-bargaining unit members may apply but require Superintendent's approval.
<input type="checkbox"/> Career Change (can only be used to change to a non-teaching career) CTA (membership not required)	Attach a letter from employee indicating the planned career change.
<input type="checkbox"/> Under school	Attach a letter from the Charter School.
<input type="checkbox"/> Military	Attach appropriate orders when available.
<input type="checkbox"/> Political Leave	No attachments necessary.

BA BARGAINING UNIT/ROLL UP (check one only)
 CTA FPSU ABBOP PBA Administrative Confidential/Miscellaneous Other

Signature of Employee Making Request _____ Date _____ Signature of Principal/Department Head _____ Date _____
 PBSO 1666 (Rev. 03/21/2009) 36 P 2/20

Leave Application

- Please attach all required documentation when completing form PBSB 1666. Required documentation is described on the right hand side of form.



THE SCHOOL DISTRICT OF PALM BEACH COUNTY
Request for Leave of Absence Without Pay
 Initial Request Extension

DIRECTIONS: If you are submitting this form for an initial leave check "Initial Request" above and complete section A. If you are requesting an extension to an existing leave check "Extension" above and complete section B. Incomplete form will not be approved.
 Leaves of absence (pursuant to School Board Policy 3.00 or collective bargaining agreement) will be approved by the Superintendent's designee prior to final School Board action. If requesting Family Medical Leave Act (FMLA) attach the appropriate FMLA District form (PBSB 2312, 2313, 2314, or 2315).

Name	Social Sec # (last 4 digits only)	Employee ID #
Position	School Department	

SECTION A - INITIAL REQUEST
 Complete this section if this is your first request for leave without pay.

Date of last day worked _____

Date of last sick day used _____

Initial here if you are choosing not to use sick days
 (use only when applying for Maternity or Sick Leave)

Expected return date _____

SECTION B - EXTENSION REQUEST
 Complete this section if your purpose is to extend your initial request for leave without pay.

Revised date returning to work _____

TYPE OF LEAVE REQUESTED	DOCUMENTATION REQUIRED
<input type="checkbox"/> Sick Leave <input type="checkbox"/> Self <input type="checkbox"/> Immediate Family Member <input type="checkbox"/> Personal Medical / PSU / PBA (attach documentation) <input type="checkbox"/> Workers Compensation	Attach a doctor's statement indicating the medical facts to support the need for the leave and the required time of absence or if requesting FMLA attach the appropriate FMLA District form (PBSB 2312, 2313, 2314 or 2315).
<input type="checkbox"/> Maternity/Child Care	Attach a doctor's statement indicating the pending date of birth (PBSB 2312 or 2313). Attach a letter indicating date of placement/adoption/ foster care.
<input type="checkbox"/> Personal (includes student teaching) <input type="checkbox"/> Administrative & Non-Instructional <input type="checkbox"/> Long Term Leave CTA (membership not required) <input type="checkbox"/> Personal Non-medical / PSU / PBA	Attach a letter from employee outlining the specific need/hardship. Personal Non-medical must be approved by Principal/Department Head.
<input type="checkbox"/> Professional CTA (membership not required)/Non-bargaining	Attach a letter from employee indicating the type of professional activity. Non-bargaining unit members may apply <u>but</u> require Superintendent's approval.
<input type="checkbox"/> Career Change (can only be used to change to a non-teaching career) CTA (membership not required)	Attach a letter from employee indicating the planned career change.
<input type="checkbox"/> Charter School	Attach a hiring letter from the Charter School.
<input type="checkbox"/> Military	Attach appropriate orders when available.
<input type="checkbox"/> Political Leave	Work assignments necessary.

BARGAINING UNIT GROUP (check one only)

CTA FPSU ABEOP PBA Administrative Confidential/Miscellaneous Other

Signature of Employee Making Request	Date	Signature of Principal/Department Head	Date
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PBSB 1666 (Rev. 02/21/2009) 56-P-930

Family Medical Leave Act (FMLA)

Eligibility

Employees must have at least 1 year of service and have worked at least 1250 hours within the last 12 months.

Basic FMLA Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:


- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.
- To care for covered serviceman who has a serious injury or illness incurred in the line of duty or active duty (up to 26 weeks)
- Military Qualifying Exigencies (12 weeks)



Family Medical Leave Act (FMLA) Health Care Provider for Employee's Serious Health Condition Certification

Form PBSD 2312

- ❖ Form required to be submitted with the PBSD 1666
- ❖ Form required when the employee is applying for unpaid leave for his/her own illness
- ❖ Form required when employee is applying for childcare/maternity leave
- ❖ Certification must be completed and signed by the attending physician



THE SCHOOL DISTRICT OF PALM BEACH COUNTY

Family Medical Leave Act (FMLA)

Health Care Provider for Employee's

Serious Health Condition Certification

PRINT OUT TYPE

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

Employee Name _____ Employee ID # _____

Employee Work Location _____

Employee Job Title _____

Signature of Employee

Date

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts listed below. 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 "lifelong," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Page two (2) provides space for additional information, should you need it. Be sure to sign the form on page 2.

Health Care Provider _____

Type of Practice/Medical Specialty _____

Health Care Provider Business Address _____

Telephone # _____ Fax # _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced _____

Probable duration of condition _____ Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? Yes No

If yes, dates of admissions _____

Date(s) you treated the patient's condition _____

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

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

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)? Yes No If yes, state the nature of such treatment and expected duration of treatment. _____

2. Is the medical condition pregnancy? Yes No If yes, expected delivery date _____

PBSD 2312 (New 05/05/2009) ORIGINAL - Compensation & HR Planning COPY - Employee page 1 of 2

Must be filled out

Leave Duration required

Family Medical Leave Act (FMLA) Health Care Provider for Employee's Serious Health Condition Certification

Form PBSD 2312

page2

3. Use the information provided by the employee in Section 1 to answer this question. If the employee's essential job functions or job description is not provided, answer these questions based upon the employee's own description of his/her functions.

Is the employee unable to perform any of his/her job functions due to the condition? Yes No

If so, identify the job functions the employee is unable to perform. _____

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

PART B: AMOUNT OF LEAVE NEEDED

5. Will the employee be incapacitated for a single continuous period of time due to the medical condition, including any time for treatment and recovery? Yes No

If yes, estimate the beginning (date) _____ and ending (date) _____ dates for the period of incapacity.

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? Yes No

If yes, are the treatments or the reduced number of hours of work medically necessary? Yes No

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

Estimate the part-time or reduced work schedule the employee needs, if any: hour(s) per day _____
days per week _____ from (date) _____ through (date) _____

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing required job functions? Yes No

Is it medically necessary for the employee to be absent from work during the flare-ups? Yes No

If yes, explain: _____

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

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

Duration: hours _____ day(s) per episode _____

8. **ADDITIONAL INFORMATION:** Identify question number with your additional answer.

Signature Required


Signature of Health Care Provider

Date

Leave Duration
required

Family Medical Leave Act (FMLA) Health Care Provider for Family Member's Serious Health Condition Certification Form PBSD 2313

- ❖ Form required to be submitted with the PBSD 1666
- ❖ Form required when the employee is applying for an unpaid leave to care for an immediate family member



THE SCHOOL DISTRICT OF PALM BEACH COUNTY

Family Medical Leave Act (FMLA)

Health Care Provider for Family Member's Serious Health Condition Certification

PRINT OR TYPE

INSTRUCTIONS FOR EMPLOYEE: Complete the following questions before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections, pursuant to 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request, pursuant to 29 C.F.R. §825.313. Your employer must give you at least fifteen (15) calendar days to return this form to your employer, pursuant to 29 C.F.R. § 825.305.

Employee name _____ Employee ID # _____

Family Member for Whom You Will Provide Care _____

Relationship of Family Member to You _____

If the family member is your son or daughter, provide date of birth. _____

Describe care you will provide to your family member and estimate leave time needed to provide care. _____

Signature of Employee _____
Date

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answers should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient's family member is seeking leave. Page Two (2) provides space for additional information, should you need it. Be sure to sign the form on page 2. Provide original to employee.

Health Care Provider _____

Type of Practice/Medical Specialty _____

Health Care Provider Business Address _____

Telephone # _____ Fax # _____

PART A: MEDICAL FACTS

1. Approximate date condition commenced _____

Probable duration of condition _____ Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? Yes No

If yes, dates of admissions _____

Date(s) you treated the patient's condition _____

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

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

Must be filled out

Leave Duration Required

Family Medical Leave Act (FMLA) Health Care Provider for Family Member's Serious Health Condition Certification Form PBSD 2313 page2

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

Yes No If yes, state the nature of such treatment and **expected duration of treatment.** _____

2. Is the medical condition pregnancy? Yes No If yes, expected delivery date _____

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment). _____

PART B: AMOUNT OF CARE NEEDED

When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care.

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment or recovery? Yes No

If yes, estimate the beginning _____ and ending _____ dates for the period of incapacity.

During this time will the patient need care? Yes No

Explain the care needed by the patient and why such care is medically necessary. _____

5. Will the patient require follow-up treatments, including any time for recovery? Yes No

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

6. Will the patient require care on an **intermittent** or **reduced scheduled** basis, including any time for recovery?

Yes No Estimate the hours the patient needs care on an **intermittent** basis, if any:

hour(s) per day _____ days per week _____ from (date) _____ through (date) _____

Explain the care needed by the patient, and why such care is medically necessary. _____

7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? Yes No Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may incur over the next six (6) months (e.g., 1 episode every 3 months lasting 1-2 days):

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

Duration: _____ hours _____ day(s) per episode

Does the patient need care during these flare-ups? Yes No

Explain the care needed by the patient, and why such care is medically necessary. _____

8. **ADDITIONAL INFORMATION:** Identify question number with your additional answer.

Signature Required

Signature of Health Care Provider

Date

Family Medical Leave Act (FMLA) Health Care Provider for a Covered Servicemember Certification


Form PBSD 2314

Military Family Leave Entitlements

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the servicemember medically unfit to perform his or her duties for which the servicemember is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

- ❖ Form required to be submitted with the PBSD 1666

Must be filled out



THE SCHOOL DISTRICT OF PALM BEACH COUNTY
Family Medical Leave Act (FMLA)
Health Care Provider for a
Covered Servicemember Certification

SECTION I: For completion by the EMPLOYEE and/or the COVERED SERVICEMEMBER for whom the employee is requesting leave. (This section must be completed before any of the below sections can be completed by a health care provider.)

PART A: EMPLOYEE INFORMATION
 Name and address of employer (this is the employer of the individual requesting leave to care for a covered servicemember): The School District of Palm Beach County
Compensation and HR Planning
3300 Forest Hill Blvd., A-115
West Palm Beach, FL 33406

Provide name and ID number of employee requesting leave to care for a covered servicemember.
 Employee Name _____ Employee ID# _____

Provide name of covered servicemember for whom the employee is requesting leave to care for.
 Covered Servicemember Name _____

Relationship of Employee to Covered Servicemember:
 Spouse Parent Son Daughter Next of Kin

PART B: COVERED SERVICEMEMBER INFORMATION

1. Is the covered servicemember a current member of the regular Armed Forces, the National Guard or Reserves?
 Yes No If yes, provide the covered servicemember's military branch, rank, and unit currently assigned.

Is the covered servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces who are receiving medical care as outpatients (such as a medical hold or war/transition unit)? Yes No If yes, provide the name of the medical treatment facility or unit. _____

2. Is the covered servicemember on the Temporary Disability Retired List (TDRL)? Yes No

PART C: CARE TO BE PROVIDED TO THE COVERED SERVICEMEMBER
 Describe the care to be provided to the covered servicemember and an estimate of the leave duration needed to provide care.

SECTION II: For completion by a United States Department of Defense ("DOD") Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; or (3) a DOD non-network TRICARE authorized private health care provider. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). (Section I above must be completed before completing this section.) Be sure to sign the form on the last page.

PBSD 2314 (Rev 05/25/2008) ORIGINAL - Compensation & HR Planning COPY - Employee page 1 of 2

Family Medical Leave Act (FMLA) Health Care Provider for a Covered Servicemember Certification

Form PBSD 2314

page2

PART A: HEALTH CARE PROVIDER INFORMATION

Type of Practice/Medical Specialty _____

Health Care Provider _____ Fax # _____

Telephone # _____ E-mail Address _____

Health Care Provider Business Address _____

PART B: MEDICAL STATUS

1. Covered servicemember's medical condition is classified as (check **one** of the appropriate boxes):

(VSI) **Very Seriously Ill/Injured** - Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Note this is an internal DOD casualty assistance designation used by DOD health care providers.)

(SI) **Seriously Ill/Injured** - Illness/Injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Note this is an internal DOD casualty assistance designation used by DOD health care providers.)

OTHER Ill/Injured - A serious injury or illness that may render the servicemember medically unfit to perform the duties of the member's office, grade, rank, or rating.

NONE OF THE ABOVE (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a "serious health condition" under § 825.113 of the FMLA. If such leave is requested, you may be required to complete a FMLA Health Care Provider for Family Member's Serious Health Condition Certification (PBSD 2313) form.)

2. Was the condition for which the covered servicemember is being treated incurred in the line of duty on active duty in the Armed Forces? Yes No

3. Approximate date condition commenced _____

4. Probable duration of condition and/or need for care _____

5. Is the covered servicemember undergoing medical treatment, recuperation, or therapy? Yes No

If yes, describe medical treatment, recuperation or therapy _____

PART C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

1. Will the covered servicemember need care for a single continuous period of time, including any time for treatment and recovery? Yes No

If yes, estimate the beginning and ending dates for this period of time _____


2. Will the covered servicemember require periodic follow-up treatment appointments? Yes No

If yes, estimate the treatment schedule _____

3. Is there a medical necessity for the covered servicemember to have periodic care for these follow-up treatment appointments? Yes No

4. Is there a medical necessity for the covered servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? Yes No

If yes, estimate the frequency and duration of the periodic care _____



Signature of Health Care Provider

Date


PBSD 2314 (New 05/26/2009) ORIGINAL - Compensation & HR Planning COPY - Employee Page 2 of 2

Family Medical Leave Act (FMLA) Military Qualifying Exigency Certification

Form PBSD 2315

Military Family Leave Entitlements

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.



THE SCHOOL DISTRICT OF PALM BEACH COUNTY

Family Medical Leave Act (FMLA) Military Family Leave Qualifying Exigency Certification

PRINT OR TYPE

INSTRUCTIONS FOR EMPLOYEE: Complete the following fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "unknown" or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit, pursuant to 29 C.F.R. § 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least fifteen (15) calendar days to return this form to your employer.

Provide the name and employee ID number of the employee requesting leave to care for covered servicemember.

Employee Name _____ Employee ID # _____

Provide the information below of the servicemember for whom the employee is requesting leave to care for.

Service Member Name _____ Spouse Parent Son
 Period of covered military member's active duty _____ Daughter Next of Kin

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a covered military member's active duty or call to active duty status in support of a contingency operation. Check one of the following:

A copy of the covered military member's active duty orders is attached.

Other documentation from the military certifying that the covered military member is on active duty (or has been notified of an impending call to active duty) in support of a contingency operation is attached.

I have previously provided my employer with sufficient written documentation confirming the covered military member's active duty or call to active duty status in support of contingency operation.

PART A: Employee Requesting Leave

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (include the specific reason for your leave request). _____

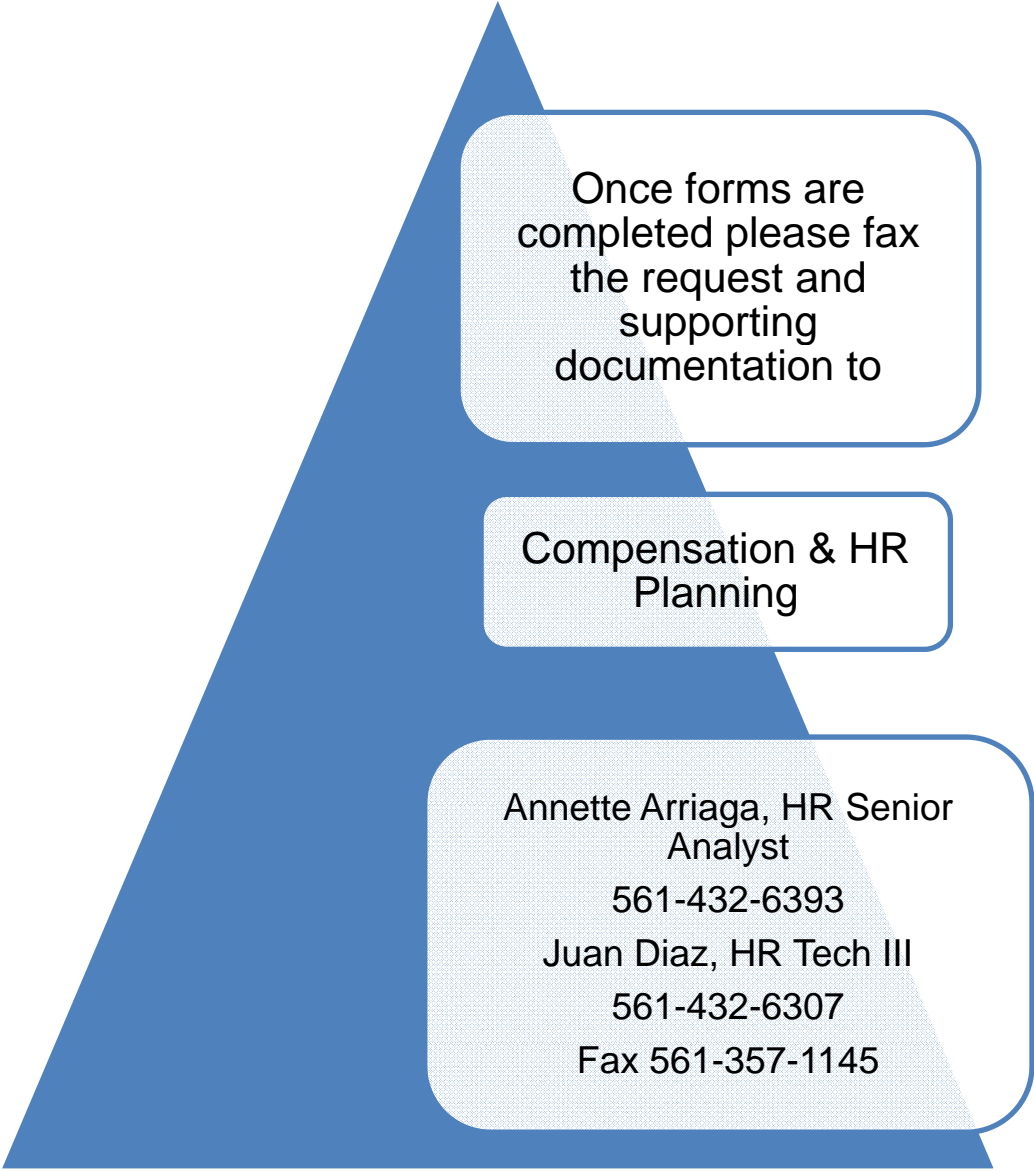
2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave. Such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military, a document confirming an appointment with a counselor or school official, or a copy of a bill for services for the handling of legal or financial affairs. Is written documentation supporting this request for leave attached?

Yes No None Available

PBSD 2315 (New 05/26/2009) ORIGINAL - Compensation & HR Planning COPY - Employee

Page 1 of 2

Submitting Leave Request



Once forms are completed please fax the request and supporting documentation to

Compensation & HR Planning

Annette Arriaga, HR Senior Analyst

561-432-6393

Juan Diaz, HR Tech III

561-432-6307

Fax 561-357-1145

Check Leave Status on People Soft

1. Click on the link under Job Information identified as Workforce Administration then click on Job Data.
2. Enter the employee **EMPLID** number and click the Include History then click **Search**.

Menu

Search:

- My Favorites
- PB Interfaces
- Self Service
- Manager Self Service
- Recruiting
- Workforce Administration
 - Personal Information
 - Job Information
 - Contract Administration
 - Temporary Assignments
 - Employment Categorization ITA
 - Review Job Information
 - PB Online Job Action Requests
 - Reports
 - Job Data**
 - Add Employment Instance
 - PB Probation Rules
 - Add Contingent Worker Instance
 - Add Additional Assignment
 - Current Job

Job Data

Enter any information you have and click Search. Leave fields blank for a list of all values.

Find an Existing Value

EmplID: begins with

Empl Rcd Nbr: =

Name: begins with

Last Name: begins with

Second Name: begins with

Alternate Character Name: begins with

Middle Name: begins with

Include History Case Sensitive

[Basic Search](#)

Check Leave Status on People Soft

3. PB Job Data Page will display

- ❖ HR Status will be Active and Payroll Status will reflect Leave of Absence.
- ❖ Action / Reason will reflect Leave of Absence and the type of leave
- ❖ On the right mid section will be the employee's expected return date

The screenshot shows the 'Job Information' tab of the PeopleSoft Job Data page. The employee's HR Status is 'Active' and Payroll Status is 'Leave of Absence'. The Action / Reason is 'Leave of Absence' with a sub-reason of 'Professional Leave'. The Expected Return Date is 12/15/2009. The Date Created is 05/13/2009. Other fields include Last Start Date (08/04/2004), Last Date Worked (06/05/2009), and Position Number (10049191).

Work Location	Job Information	Job Labor	Payroll	Salary Plan	Compensation
EMP	ID:	Empl Rcd #:	0		
Work Location	Find	First	1 of 1	Last	
HR Status:	Active	Payroll Status:	Leave of Absence		
*Effective Date:	06/05/2009	Sequence:	0	*Job Indicator:	Primary Job
Action / Reason:	Leave of Absence		Professional Leave		
Last Start Date:	08/04/2004	Termination Date:			
Expected Job End Date:		<input type="checkbox"/> End Job Automatically			
Last Date Worked:	06/05/2009	<input checked="" type="checkbox"/> Override Last Date Worked	Expected Return Date:	12/15/2009	
Position Number:	10049191	TCH ESE VE	Position Entry Date:	08/02/2008	
Regulatory Region:	USA	United States			
Company:	PBC	School Dist of Palm Beach Co			
Business Unit:	SDPBC	School Dist of Palm Beach Co			
Department:	0611	Palm Springs Middle	Department Entry Date:	08/04/2004	
Location:	0611	Palm Springs Middle			
Establishment ID:	SDPBC	School Dist Of Palm Beach Co			
			Date Created:	05/13/2009	
Job Data	Employment Data	Earnings Distribution	Benefits Program Participation		

Return From Leave

Returns from leaves are processed through Online Job Actions. Please refer to your Online Job Action Aid.

TIP: An employee returning from sick leave requires a doctor's note returning them from leave. The employee must be able to perform their primary job functions. If you need assistance determining if an employee is able to perform their primary job functions please contact your HR Manager.


*TIP: Please **do not** process a return from leave until the employee is physically back to work.*

The screenshot shows a web application interface for searching PB Online Job Action Requests. On the left is a 'Menu' sidebar with a search box and a list of categories including My Favorites, PB Interfaces, Self Service, Manager Self Service, Recruiting, Workforce Administration, Personal Information, Job Information, Contract Administration, Temporary Assignments, Employment, Categorization ITA, Review Job Information, PB Online Job Action Requests (highlighted), PB Review Job Actions, Reports, and Job Data. The main content area is titled 'PB Online Job Action Request' and includes a search instruction: 'Enter any information you have and click Search. Leave fields blank for a list of all values.' Below this is a 'Find an Existing Value' section with search criteria: EmplID (begins with), Empl Rcd Nbr (=), Position Number (begins with), Name (begins with), Last Name (begins with), and Department (begins with). There is an unchecked 'Case Sensitive' checkbox. At the bottom are buttons for 'Search', 'Clear', 'Basic Search', and 'Save Search Criteria'.

Family Member Sick Leave Transfer Request

Form PBSD 1791


- ❖ Form can be used when an employee has depleted all of their sick time
- ❖ Transfer can only be from a immediate family member
- ❖ If transfer exceeds 24 hours the recipient is required to also submit a medical certification
- ❖ If employee will be going out on unpaid leave after sick days are used please submit a copy of this form and documentation with the leave application.

	<p>THE SCHOOL DISTRICT OF PALM BEACH COUNTY</p> <h3 style="margin: 0;">Family Member Sick Leave Transfer Request</h3>
<p>Section 1012.61 of Florida Statutes allows a district employee to transfer sick leave to a spouse, child, parent or sibling who is also a district employee. (School Board Policy 3.80 also includes domestic partners and the children in that list) In-law and step relationships are excluded. Transferred sick leave cannot benefit the recipient until their accrued sick leave balance has been depleted. The recipient may be eligible for holiday pay, if applicable, as a result of transferred sick leave. Depleted sick leave shall have no terminal value as provided in Florida Statute 1012.61(2). To authorize the transfer of sick leave from one employee to another, this form must be completed and submitted to the Department of Compensation and HR Planning.</p> <p>If transfer request exceeds 24 hours the recipient must submit a medical certification to support the transfer request. The medical certification must include the employee's name, condition and duration to support the transfer request.</p>	
<p>SECTION I - Transferring Employee The transferring employee is the employee who wants to transfer sick leave to a family member who is also employed by the district.</p> <ul style="list-style-type: none"> • Accrued sick leave balance will be reduced by each transfer. • Date and signature are required to authorize the transfer and must be notarized 	
Employee Name (first, middle, last)	Employee ID #
Employee Position/Title	Employee Work Location
<p>Number of sick hours to be transferred _____</p> <p>I solemnly swear and truthfully affirm that I am related to recipient, (with name) _____, as his/her (relationship) _____. I understand that any false statements on this form will result in disciplinary action.</p>	
_____ Signature of Employee Transferring Sick Leave	_____ Date
<p>SECTION 1 A - To be completed by a Notary Public STATE OF FLORIDA, COUNTY OF _____ Sworn to and subscribed to me this _____ day of _____, _____ by _____, who is personally known to me or who has produced _____ as the certification.</p>	
_____ Signature of Notary Public	_____ Date
_____ Print Name	_____ Expiration Date
<p>SECTION II - Recipient Employee Recipient employee is the employee who will receive transferred sick leave from a family member who is also employed by the district.</p> <ul style="list-style-type: none"> • Employee must be in a position that is eligible to accrue sick leave. • Employee must deplete sick leave balance before transferred sick leave can occur. 	
Employee Name (first, middle, last)	Employee ID #
Employee Position/Title	Employee Work Location
_____ Signature of Recipient Employee	
_____ Date	
<p>PBSD 1791 (Rev. 05/23/2009) FS 1012.61(2) SBP 3.80 ORIGINAL - Compensation and HR Planning</p>	

Sick and / or Annual Leave Transfer Request for Non-Bargaining Unit Employees Family Member Sick Leave Transfer Request

Form PBSD 2175

- ❖ Form can be used when an employee has depleted all of their sick time
- ❖ If transfer exceeds 24 hours the recipient is required to also submit a medical certification
- ❖ If employee will be going out on unpaid leave after sick days are used please submit a copy of this form and documentation with the leave application.



THE SCHOOL DISTRICT OF PALM BEACH COUNTY

**Sick and /or Annual Leave Transfer Request
for Non-Bargaining Unit Employees**

School Board Policy 3.80 allows a non-bargaining unit employee to transfer accrued sick leave and, if applicable, accrued annual leave to another non-bargaining unit employee as sick leave. Transferred leave cannot benefit the recipient until his/her sick leave balance has been depleted and, if applicable, annual leave balance has been depleted. To authorize the transfer of leave from one non-bargaining unit employee to another non-bargaining unit employee as sick leave, this form must be completed and submitted by the employee to the Department of Compensation and Employee Information Services.

SECTION I - Transferring Employee

The transferring employee is the non-bargaining unit employee who wants to transfer sick and/or, if applicable, annual leave to another non-bargaining unit employee as sick leave.

- Accrued sick and/or annual leave balance will be reduced by each transfer.
- Oath and signature are required to authorize the transfer and must be notarized.

EMPLOYEE NAME (last, first, middle)	EMPLOYEE ID NUMBER
EMPLOYEE POSITION/TITLE	EMPLOYEE WORK LOCATION

Number of hours of: a) sick leave to be transferred _____ b) annual leave to be transferred as sick leave _____

I solemnly swear and truthfully affirm that I am a non-bargaining unit employee who wishes to transfer the number of sick and/or annual leave day(s) as indicated above to the non-bargaining unit employee (as listed in Section II) as sick leave. I understand that any false statement on this form will result in disciplinary action.

SIGNATURE OF EMPLOYEE TRANSFERRING LEAVE DATE

SECTION 1 A - To be completed by a Notary Public

STATE OF FLORIDA, COUNTY OF _____

Sworn to and subscribed to me this ____ day of January, _____ by _____

who is personally known to me or who has produced _____ as identification.

SIGNATURE OF NOTARY PUBLIC DATE

PRINT NAME EXPIRATION DATE

SECTION II - Recipient Employee

Recipient employee is the non-bargaining unit employee who will receive transferred sick leave and, if applicable, annual leave transferred as sick leave from another non-bargaining unit employee.

- Employee must be in a non-bargaining position that is eligible to accrue sick leave.
- Employee must deplete sick leave and, if applicable, annual leave before transferred leave can occur.

EMPLOYEE NAME (last, first, middle)	EMPLOYEE ID NUMBER
EMPLOYEE POSITION/TITLE	EMPLOYEE WORK LOCATION

PBSD 2175 (Rev. 1/16/2007) ORIGINAL - Compensation and Employee Information Services

Paid Leaves

Sabbatical Leave: Instructional employees after each six (6) consecutive years of satisfactory service in the District as an employee as defined in Article I, Section A, employees may apply for a year's leave of absence for professional academic advancement. If selected based on contract criteria these employees will receive half of their salary. The employee is required to submit a letter requesting the leave by May 1st for the following year.

CTA Sick Bank: Instructional staff who runs out of sick leave and who are part of the CTA sick bank will need to apply directly to CTA. If approved, CTA will notify the District.

Catastrophic Leave: This is a District benefit for illness or injury defined as a medical condition not covered by Workers' Compensation requiring absence from work greater than fifty (50) working days of consecutive absence for a single illness or injury. Employee will be required to submit a letter to us and two (2) medical verifications of such catastrophic illness or injury. This paid leave benefit may not be used if the instructional employee is a member of the CTA sick bank.

Reassignment Pool

Per CTA agreement a school or department must hold the teachers position for one full year. Once the employee is out for over 12 months and 1 day the principal/department head can request the teacher be transferred to the reassignment pool by emailing Annette Arriaga at arriagaa@palmbeach.k12.fl.us the request. Once request has been approved and transferred Annette will email you the letter that will need to be mailed to the employee notifying them of the reassignment.

Expired Leave

When an employee's leave expires and they do not return from leave or when an employee fails to apply for a leave extension send an email to : arriagaa@palmbeach.k12.fl.us the request. Once request has been approved and processed Annette will email you the letter that will need to be mailed to the employee notifying them of the reassignment.

Job Abandonment

If the employee is out more than 3 consecutive days and has not contacted the school/department, please contact Britoni Garson in Employee Relations at (561) 357-7505.

If you need further assistance you can also contact the HR Customer Contact Center at 561-434-8777 (px48777) or via email at AskHR@palmbeach.k12.fl.us.