



**MIAMI-DADE COUNTY PUBLIC SCHOOLS
INTERMITTENT LEAVE REQUEST MEDICAL CERTIFICATION
UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)**

For Completion by the EMPLOYEE: (SUBMIT TO WORKSITE ADMINISTRATOR)

SUPERVISORS: Please submit completed form to the Leave Office via email to Leave@dadeschools.net.

EMPLOYEE NAME (PRINT)

EMPLOYEE NUMBER

FOR ILLNESS OF EMPLOYEE OR FOR ILLNESS OF FAMILY MEMBER _____
Family Member Name & Date of Birth

If request is for illness of family member indicate the relationship _____ and age _____ if it is for a son or daughter (must be accompanied by FM-7497).

I hereby authorize Miami-Dade County Public School's healthcare representative to contact my healthcare provider for purposes of verification, clarification and/or authentication of the information on this form.

I certify, under the penalty of perjury and disciplinary action, including, but not limited to termination of employment, that the foregoing information is true and correct. I also understand that my or my healthcare representative's failure to cooperate in the verification of the foregoing information may result in denial of the FMLA request. I further understand that I may not take leave without approval and that said unapproved leave may constitute abandonment of my employment and may result in disciplinary action, including, but not limited to termination of employment.

The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support your request for FMLA. Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. Time taken as part of the intermittent leave request constitutes designation of your FMLA entitlement.

EMPLOYEE SIGNATURE

DATE

For Completion by the Healthcare Provider: _____
Patient Name

Describe relevant medical facts related to the condition; such as symptoms, diagnosis or any regimen of continuing treatment.

- Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery?
Yes _____ No _____
- Recommended intermittent leave of absence dates are from _____ to _____
Date (be specific) Date (be specific)
- Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions?
Yes _____ No _____
- Is it medically necessary for the employee to be absent from work during the flare-ups?
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 have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):
Frequency: _____ times per (check one) week OR month
Duration: _____ hours OR _____ consecutive day(s) per episode

PROVIDER'S COMMENTS: _____

Physician's Name Printed

Physician's Signature

Date

Specialty

Phone Number

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 1 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.

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.

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.

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.

BENEFITS & PROTECTIONS

ELIGIBILITY REQUIREMENTS

REQUESTING LEAVE

EMPLOYER RESPONSIBILITIES

ENFORCEMENT

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

