

**BIRDVILLE INDEPENDENT SCHOOL DISTRICT  
REQUEST FOR FAMILY AND MEDICAL LEAVE**

*Request for Family or Medical Leave (FMLA) must be made at least 30 days (if possible) prior to the date the requested leave is to begin. Any leave approved will require the use of all applicable sick leave and vacation time.*

**Instructions:** Complete this form, obtain the signature of your principal/supervisor and submit entire form to the BISD personnel department.

Printed Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Hire Date: \_\_\_\_\_

Position/Assignment: \_\_\_\_\_ Campus/Department: \_\_\_\_\_

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I request family or medical leave for one or more of the following reasons:

**Birth or adoption of child**

Expected date of birth \_\_\_\_\_

Date leave to start \_\_\_\_\_

Expected date to return \_\_\_\_\_

**In order to care for spouse, child or parent who has a serious health condition**

Date leave to start \_\_\_\_\_

Expected date to return \_\_\_\_\_

**Serious health condition that prevents me from performing my job**

Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date leave to start \_\_\_\_\_

Expected date to return \_\_\_\_\_

**PLEASE ATTACH MEDICAL CERTIFICATION FROM HEALTH CARE PROVIDER FOR ANY  
REQUESTED LEAVE FOR A SERIOUS HEALTH CONDITION OR BIRTH OF A CHILD.**

*(Form R-98)*

**BIRDVILLE INDEPENDENT SCHOOL DISTRICT**  
**REQUEST FOR FAMILY AND MEDICAL LEAVE**

Have you taken a family or medical leave in the past 12 months?  Yes  No

If **yes**, how many workdays did you miss due to FMLA? \_\_\_\_\_

Have you had any absences due to the condition for which you are requesting the leave?

Yes  No

If **yes**, please list the dates \_\_\_\_\_

Are you currently covered under the Birdville ISD health insurance program?  Yes  No

*If yes, the premium payment will be deducted from your payroll check as usual. If your wages become insufficient to cover the premium, you must submit a personal check to BISD to cover the insurance cost.*

***I UNDERSTAND AND AGREE TO THE FOLLOWING PROVISIONS:***

- I have worked for my employer at least one year and at least 1,250 hours in the previous months.
- All days not covered by sick leave or vacation will be unpaid.
- After 12 weeks of leave, if I am unable to return to work, I must contact my supervisor and the BISD personnel department to report my status.
- The position of non-contracted employee is not guaranteed 12 weeks.
- If I do not return to work after the leave, the Birdville ISD will recover the cost of any benefits incurred during the time of the leave.
- If the requested leave is due to my own serious health condition, I must submit medical certification of my ability to resume work.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**LEAVE APPROVALS:**

Principal: \_\_\_\_\_ Date: \_\_\_\_\_

Manager/Supervisor: \_\_\_\_\_ Date: \_\_\_\_\_

Personnel: \_\_\_\_\_ Date: \_\_\_\_\_

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**PAYROLL INSTRUCTIONS:**

With pay from \_\_\_\_\_ to \_\_\_\_\_ Total # work days \_\_\_\_\_

Without pay from \_\_\_\_\_ to \_\_\_\_\_ Total # work days \_\_\_\_\_

## **BIRDVILLE INDEPENDENT SCHOOL DISTRICT**

### ***MEDICAL CERTIFICATION FROM HEALTH CARE PROVIDER***

A “serious health condition” means an illness, injury, impairment, or physical or mental condition, that involves one of the following:

1. **Hospital care**  
Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity or subsequent treatment in connection with or consequent to such inpatient care.
2. **Absence plus treatment**  
(a) A period of incapacity of more than three consecutive calendar days (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:
  - (1) Treatment\* two or more times by a health care provider, by a nurse or physician’s assistant under direct supervision of a health care provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a health care provider, or
  - (2) Treatment by a health care provider on at least one occasion that results in a regimen of continuing treatment\* under the supervision of the health care provider.
3. **Pregnancy**  
Any period of incapacity due to pregnancy or for prenatal care.
4. **Chronic conditions requiring treatments**  
A chronic condition that meets the following conditions:
  - (1) Requires periodic visits for treatment by a health care provider, or by a nurse or physician’s assistant under direct supervision of a health care provider.
  - (2) Continues over an extended period time (including recurring episodes of a single underlying condition).
5. **Permanent/long-term conditions requiring supervision**  
A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer’s, a severe stroke, or the terminal stages of a disease.
6. **Multiple treatments (non-chronic conditions)**  
Any period of absence to receive multiple treatments (including any recovery period) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), or kidney disease (dialysis).

\* Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

\*A regimen of continuing treatment includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

**BIRDVILLE INDEPENDENT SCHOOL DISTRICT**  
***MEDICAL CERTIFICATION FROM HEALTH CARE PROVIDER***

1. Employee's Name	2. Patient's Name (if different from employee)								
<p>3. Page 4 describes what is meant by a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition qualify under any of the "serious health condition" categories described on page 4? If so, please check the applicable category:</p> <table style="width: 100%; border: none;"><tr><td style="width: 50%;">1. <input type="checkbox"/> Hospital Care</td><td style="width: 50%;">5. <input type="checkbox"/> Permanent/long-term condition requiring supervision</td></tr><tr><td>2. <input type="checkbox"/> Absence plus treatment</td><td>6. <input type="checkbox"/> Multiple treatments (non chronic conditions)</td></tr><tr><td>3. <input type="checkbox"/> Pregnancy</td><td>7. <input type="checkbox"/> None of the above</td></tr><tr><td>4. <input type="checkbox"/> Chronic conditions requiring treatment</td><td></td></tr></table>		1. <input type="checkbox"/> Hospital Care	5. <input type="checkbox"/> Permanent/long-term condition requiring supervision	2. <input type="checkbox"/> Absence plus treatment	6. <input type="checkbox"/> Multiple treatments (non chronic conditions)	3. <input type="checkbox"/> Pregnancy	7. <input type="checkbox"/> None of the above	4. <input type="checkbox"/> Chronic conditions requiring treatment	
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4. <input type="checkbox"/> Chronic conditions requiring treatment									
<p>4. Describe the medical facts that support your certification, including a brief statement as to how the medical facts meet the criteria of one of the categories listed above.</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>									
<p>5. a. State the approximate date the condition commenced and the probable duration of the condition and also the probable duration of the patient's present incapacity (if different).</p> <hr/> <hr/> <hr/> <hr/>									
<p>b. Will it be necessary for the employee to work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in item 6 below)?</p> <p><input type="checkbox"/> Yes (give the probable duration): _____</p> <p><input type="checkbox"/> No</p>									
<p>c. If the condition is a chronic condition or pregnancy, state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity.</p> <hr/> <hr/> <hr/> <hr/>									

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***MEDICAL CERTIFICATION FROM HEALTH CARE PROVIDER***

6. a. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatment.

\_\_\_\_\_

If the patient will be absent from work or other daily activities because of treatment on an intermittent or part time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery if any:

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

- b. If any of these treatments will be provided by another provider of health services (e.g., physical therapist), please state the nature of the treatments:

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

- c. If a regimen of continuing treatment of the patient is required under your supervision, provide a general description of such regimen (e.g., prescription drugs, physical therapy requiring special equipment):

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

7. a. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or chronic condition), is the employee unable to perform work of any kind?

Yes       No

- b. If able to perform some work, is the employee unable to perform any one or more of the essential functions of his or her job (the employee or the employer should supply you with information about the essential job functions)?

Yes, please list the essential functions the employee is unable to perform.

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

No

- c. If neither *a* nor *b* applies, is it necessary for the employee to be absent from work for treatment?

Yes       No

**BIRDVILLE INDEPENDENT SCHOOL DISTRICT  
MEDICAL CERTIFICATION FROM HEALTH CARE PROVIDER**

8. a. If leave is required to care for an employee's family member with a serious health condition, does the patient require assistance for basic medical or personal needs, safety, or transportation?

Yes       No

b. If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?

Yes       No

c. If the patient will need care only intermittently or on a part time basis, please indicate the probable duration of this need:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of health care provider	Type of practice
Address	Telephone

***To be completed by the employee needing family leave to care for a family member.***

State the care you will provide and estimate the period of time during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

- a. Here and elsewhere on this form, the information sought relates only to the condition for which the employee is taking FMLA leave.
- b. "Incapacity", for purposes of FMLA, is defined to mean inability to work, attend school, or perform other regular daily activities due to the serious health condition, its treatment, or the patient's recovery.