Brevard County Public Schools

Leaves of Absence
Information & Application Packet

Compensation & Benefits Office
2700 Judge Fran Jamieson Way
Viera, Florida 32940
Phone: 321-633-1000
Fax: 321-617-7778

Revised – 07-08
Documents in the employee leave and information packet are used to:

- Inform an employee of his/her rights and procedures to follow under the School Board’s policies for Leaves of Absence including Family and Medical Leave Act (FMLA), Personal, Prof/Educational Study and Military.
- Review your rights under the Family and Medical Leave Act of 1993.
- Obtain a Leave of Absence Request Form.
- Obtain FMLA Certification of Health Care Provider.
- Obtain Sick Bank Application and Guidelines.
- Contact the Hartford Group Benefits at 1-800-303-9744 for STD information.
- Obtain Brevard County Schools Unpaid Leave of Absence Information.
- Obtain Brevard County Schools Unpaid Benefit Continuation Information for Unpaid Leaves.
- Obtain Return to Work Medical Certification that an employee is able to return to work from a Family and Medical Leave (FMLA) and any other Medical Leave to include workers compensation and disability

This checklist should be used when an employee requests a leave of absence – whether paid or unpaid.

### Reason for Leave

- Own serious health/medical condition.
- Extended Illness (60 days).
- To care for a newborn.
- To bond with a child in connection with adoption or foster placement.
- To care for a child, spouse, parent or registered domestic partner with a serious health condition.
- Injury in the line-of-duty (WC). 10 Paid days max per year.
- Military
- Personal
- Prof/Educational Study
- Other: ______

### Test for Eligibility – FMLA

- Requested Leave Start Date: ______
- Employee has: □ At least 12 months cumulative service.
- Worked at least 1250 hours in the 12 months prior to leave start date.
- Instructional Employee: □ Must have worked at least one full semester during the school year.
- Is employee eligible for FMLA? □ Yes □ No
- Has this employee used FMLA within the last 12 months? □ Yes □ No
- Remaining entitlement: ______ weeks ______ days ______ hours

### Leave of Absence Information & Application Packet

- Leave of Absence Request Form (all LOA’s)

**Provide to Employee for Medical LOA:**

- Rights and Obligations under FMLA
- FMLA Medical Certification Form
- Return to Work Medical Certification Form

**Provided By:**

**Method:** □ In Person □ Certified Mail □ Other: ______

### Action Checklist

- Received FMLA Certification. □ Received Physician’s Statement. Date: ______
- Copy of LOA Request Form given to employee. Date: ______
- Original LOA Request Form sent to Leave Specialist. Date: ______
- Received Return to Work Medical Certification. Date: ______

### Department Signature- Site Contact

School-Department Number /Date

Please send signed Leave of Absence Checklist, Leave of Absence Request Form, Physician’s Statement and FMLA Certification to the Leave Specialist at the Office of Compensation and Benefits.

**Employee Signature:**

My signature signifies that I have read the information on this form and understand my rights and responsibilities specifically those under the Family and Medical Leave Act (FMLA). I certify that the information submitted on this request is accurate.

Form Updated 6-26-08
Your Rights under the Family and Medical Leave Act of 1993

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons. Employees are eligible if they have worked for their employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 employees within 75 miles. The FMLA permits employees to take leave on an intermittent basis or to work a reduced schedule under certain circumstances.

Reasons for Taking Leave:

Unpaid leave must be granted for any of the following reasons:
• 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.

At the employee's or employer's option, certain kinds of paid leave may be substituted for unpaid leave.

Advance Notice and Medical Certification:

The employee may be required to provide advance leave notice and medical certification. Taking of leave may be denied if requirements are not met.
• The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable."
• An employer may require medical certification to support a request for leave because of a serious health condition, and may require second or third opinions (at the employer's expense) and a fitness for duty report to return to work.

Job Benefits and Protection:

• For the duration of FMLA leave, the employer must maintain the employee's health coverage under any "group health plan."

• Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
• The use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Unlawful Acts by Employers:

FMLA makes it unlawful for any employer to:
• interfere with, restrain, or deny the exercise of any right provided under FMLA:
• discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement:

• The U.S. Department of Labor is authorized to investigate and resolve complaints of violations.
• An eligible employee may bring a civil action against an employer for violations.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

For Additional Information:

If you have access to the Internet visit our FMLA website: http://www.dol.gov/esa/whd/fmla. To locate your nearest Wage-Hour Office, telephone our Wage-Hour toll-free information and help line at 1-866-4USWAGE (1-866-487-9243); a customer service representative is available to assist you with referral information from 8am to 5pm in your time zone; or log onto our Home Page at http://www.wagehour.dol.gov.

U.S. Department of Labor
Employment Standards Administration
Wage and Hour Division
Washington, D.C. 20210

WH Publication 1420
Revised August 2001

*U.S. GOVERNMENT PRINTING OFFICE 2001-476-344/49051
**Leave of Absence Request**

Used for absences in excess of 5 consecutive days excluding Vacation

Employee's (Legal) Name: ____________________________  Hours Worked: ________  Sch/Dept. #: ____________________________

Home Address: ____________________________________  Phone Number: _______________

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ACKNOWLEDGEMENTS FOR UNPAID LEAVES - ALL employees MUST initial below and sign form to complete this request.

I understand that I can use my accrued sick, personal, or vacation time before I begin an unpaid leave of absence in accordance with Board policy. I understand that the Board-paid benefit on leaves of absence for FMLA and Extended illness are only provided for a specific period of time and only cover medical, vision, and basic life. I understand since I am not receiving a paycheck, that I must pay for my benefits to continue my coverage, and it is my responsibility to assure that my premium payments are correct and current.

I wish to continue my current benefit elections by making payments to the School Board of Brevard County, (321) 633-1000 Ext. 248; otherwise, my benefits will be cancelled. (See Cost Estimator on the web at http://benefits.brevard.k12.fl.us/HR/benefits2008/2008%20PREM%20DEDUCTION%20SHEETS%20%07.9.08.pdf )

My signature signifies that I have read the information on this form and understand my rights and responsibilities specifically those under the Family and Medical Leave Act (FMLA). I certify that the information submitted on this request is accurate.

Signature of Employee: ____________________________  Date ________________

Principal/Admin/Supv                  Date ________________  Leave Approved  Disapproved

Human Resources Administrator        Date ________________  Leave Approved  Disapproved

**LOA Original: Compensation & Benefits (5 days or less retain at school/Dept.)  Blue INK ONLY  ** Copies: Payroll/Employee/Department/HR Services

(Absences in excess of 5 consecutive days excluding vacation submit to Compensation & Benefits)  10/23/08
Supplemental leave information for calendar year 2008

Brevard Public Schools Leaves Of Absence Policy

- Employees shall not be absent from their assigned duties except as authorized by the Superintendent or designated representative. An employee who is willfully absent from duty without leave shall forfeit compensation for the time of such absence. Contracts or appointments shall be subject to cancellation by the Board and the employee shall be subject to immediate dismissal.
- Employees should refer to the “Leave of Absence Procedure” for specific leave requirements.
- Bargaining unit employees refer to appropriate contract.

### COST ESTIMATOR TABLE

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**No Joint Coverage; Section 125, Imputed Income or FSA Dependent Day Care Allowed While On Unpaid Leave of Absence.**

*(After exhaustion of Board paid portion)*

*Your coverage elections are listed on your paycheck to verify cost-per-pay; cancellation of STD and/or LTD may require Evidence of Insurability in order to reinstate coverage.*

Cancellations of 2 or more times life insurance must begin at 1 times life when you return.

NOTE: “Waiver of Premium” - After an employee has an approved LTD claim, the employee no longer has to pay STD or LTD premiums.

Calculating Your Medical Premiums

**FMLA** – The Medical premium you owe per pay period while on FMLA leave is the amount you owe over and above the Board paid benefits. To determine the amount you owe per pay period, find your pay frequency (21, 22, 23, 24, 25, or 26) in the Cost Estimator Table. Read down the table until you come to your coverage election (e.g. Medical Cigna EPO Employee + Spouse). Then find the appropriate pay frequency. The result will be your Medical cost per pay period while on FMLA leave.

**ILOD** – Board paid Medical, Employee Only Vision, and 1 x Employee Life will be paid for up to 10 days. Any medical premium you might owe over the Board contribution is determined using the same procedure as for FMLA leave above.

**Illness Exhausted** – Board paid Medical, Employee Only Vision, and 1 x Employee Life will be paid up to 60 days. Any medical premium you might owe over the Board contribution is determined using the same procedure as for FMLA leave above.

**Workers Compensation** – Any medical premium you might owe over the Board contribution is determined using the same procedure as for FMLA leave above.

- **Support Employees:** Up to 75 days of Board paid Medical, Vision, and 1 x Employee Life
- **Instructional & Administration:** Up to 60 days of Board paid Medical, Vision, and 1 x Employee Life

*Health & Dependent Reimbursement Info:*
http://www.teamcornerstone.com/bps

*Current Employee Benefit Coverage Info:*
http://www.easybenefits.com/ You MUST have your Employee ID # and your 6 digit Password to enter this site.
SCHOOL BOARD OF BREVARD COUNTY, FLORIDA

SICK LEAVE BANK GUIDELINES/PROCEDURES

I. PURPOSE

The purpose of the sick leave bank shall be to make available a source from which qualifying employees may be granted additional sick leave days only for his/her inpatient surgery, emergency medical or psychological treatment in a medical facility, or treatment of a life-threatening illness.

An eight (8) member sick leave bank committee shall be appointed by the Superintendent. The Brevard Federation of Teachers (BFT) and the International Brotherhood of Painters and Allied Trades, Local 1010 (Local 1010) shall be invited to submit the names of two (2) bargaining unit members who shall be appointed to the committee. The Superintendent shall select the remaining four (4) members provided that two (2) of the Superintendent’s selectees shall be nonbargaining unit classified employees and two (2) shall be nonbargaining unit managerial employees. The committee shall serve as the final authority for all matters pertaining to the approval or disapproval of an employee’s request to seek use of the sick leave bank. Decisions and actions of the committee shall not be subject to any grievance procedure. An employee who wishes to request the committee to review its decision may submit such request in writing to the committee within fourteen (14) calendar days following the employee’s notification of such decision. Such written request shall set forth the employee’s reasons why such decision should be altered. A decision, if reviewed, shall not be reviewed a second time.

II. MEMBERSHIP

A. Membership shall become available to a full time employee only after he/she has completed at least one (1) full, current and continuous year of employment as an employee of the district. For purposes of this program only, a full time employee is defined as one who is employed in a regularly established position and working the hours per day specified for that position.

B. Membership shall be voluntary.

C. Each participating employee shall initially contribute the number of hours equal to one (1) day from his/her accrued sick leave balance provided that such balance before the deduction of the one (1) day contribution shall be no less than eight (8) days.

D. Such initial contribution shall only be allowed for the first calendar month of each school year.

E. Hours contributed to the bank shall not be returned to the contributing employee’s sick leave balance except as otherwise provided herein.

F. Written application for membership shall be properly submitted on the completed form provided for such purpose and received in the designated office during the thirty (30) calendar days as provided in paragraph “D” above.

G. Approval or disapproval of membership application and/or applications for use of the bank shall not be subject to any grievance process.

H. An employee who applies to be a member will receive written notification of membership approval or denial.

I. If a current sick leave bank member becomes a participant in the DROP program he/she may continue to participate in the sick leave bank. However, new membership will not be granted to a non sick leave bank member who is already a participant in the DROP program.
III. USAGE

A. New members with *pre-existing conditions* shall not be eligible to receive days from the sick leave bank for these pre-existing conditions for one (1) year following the date of membership in the sick leave bank.

B. Written application for utilizing the sick leave bank shall be submitted, **no later than 14 calendar days prior to the use of sick bank utilization**, on the required form provided for that purpose. **In the case of an unforeseen emergency, the sick leave bank application must be submitted within 14 calendar days of sick bank utilization.**

C. Each application shall be accompanied by a statement from a licensed Florida medical doctor stating the nature of the illness **as well as the anticipated beginning and ending date** of the employee’s absence. The committee shall have the right to require another medical opinion at the employee’s expense.

D. Eligibility for bank usage shall only be established after an employee has exhausted his/her accumulated sick leave and compensatory time and his/her illness or injury has caused him/her to be absent an additional five (5) days without pay. In lieu of five (5) unpaid days, the employee may use up to five (5) days of paid vacation if he/she is eligible for vacation and has accrued vacation time available.

E. **A member wishing to utilize sick leave bank will be required to add the number of personal charged to sick days taken in the current fiscal year to the five (5) days unpaid already required.**

F. If the member has participated in the year-end sick leave buy back, days equal to the number of days withdrawn through that buy back process will be added to the five (5) workdays without pay currently required before payment from the sick leave bank can begin. *(Effective July 1, 1995).* The maximum number of days for sick leave buy-back is ten (10).

*For example: if an employee buys back ten sick leave days at the end of the year, that employee would be in an unpaid status for fifteen days before the Sick Leave Bank benefits could begin. Ten (10) days bought back + five (5) workdays without pay = fifteen (15) days in an unpaid status. If the employee bought back two (2) sick leave days, they would be eligible for Sick Leave Bank after seven (7) days in an unpaid status.*

G. **An employee who is receiving ongoing, medically necessary treatments will be allowed to use forty (40) workdays without those days being consecutive after the five (5) unpaid sick days have been satisfied and they provide doctor statements and leave forms to cover the time used for such treatments.**

H. Pregnancy is not eligible for consideration unless a pregnancy related condition develops that would qualify under the normal sick leave bank guidelines.

I. **An employee is not eligible for use of the bank if receiving worker’s compensation or on any approved paid leave.**

J. Bank usage shall be limited to forty (40) days per member per school year and is limited to regularly scheduled work time. Additional work time, such as summer hours, is not an acceptable use of sick leave bank hours.

K. **In order to be eligible for sick leave bank benefits an employee must have been in an actively working paid status one day more than one-half of the current or prior school year.**
IV. ACTIVATION OF BANK

The sick leave bank shall only become operative upon the accumulation of four thousand (4,000) hours of contributed sick leave as provided herein.

V. TERMINATION

Termination of employment for any reason shall constitute withdrawal from the bank.

VI. MAINTENANCE AND REPLENISHMENT

The number of hours in the bank shall be maintained at thirty-two hundred (3,200). Should the number of hours in the bank fall below thirty-two hundred (3,200), each existing member shall automatically be assessed the number of hours equal to one (1) day of his/her accumulated sick leave to be added to the bank balance. Such assessment shall be accomplished as soon as procedures reasonably permit. In the event an employee’s accrued sick leave balance is insufficient to allow for such automatic replenishment, such employee shall be allowed a grace period of no more than sixty (60) school days during which time he/she must accrue the sick leave necessary to meet his/her replenishment obligation.

Failure of an employee to comply with the replenishment provision as provided herein shall cause automatic cancellation of his/her bank membership. Notification will be sent to the member when such membership is canceled.

VII. MISUSE

An employee found to be guilty of misuse of the bank shall be required to repay all sick leave drawn from the bank, have his/her membership withdrawn, be prohibited from future membership, and be subject to disciplinary action as deemed appropriate by the Board.

VIII. WITHDRAWAL

A. A participating employee who chooses to withdraw from participation in the bank shall not be allowed to withdraw any sick leave days that he/she has contributed to the bank.

B. Written notification of withdrawal from the sick leave bank shall be sent to the Payroll Department.

IX. RECORDS AND REPORTS

A. A database will be established and maintained for the use of the Sick Leave Bank Committee.

B. An annual report will be developed and made available at each work site. The report will show the total use and remaining balance in the Sick Leave Bank. Information on individual usage will not be included in this report.

C. A monthly report will be produced for use by the Sick Leave Bank Committee.

X. DISSOLUTION OF BANK

In the event it becomes necessary to dissolve the sick leave bank, the hours remaining in the bank shall be distributed equally to the accumulated sick leave balance of each of the then current members.
Brevard Public Schools

Application for Use of Sick Leave Bank
(Must be submitted at least 14 calendar days prior to the effective date of bank utilization)

Name: _________________________________  Employee ID Number: _________________________________

Phone:  Home __________________________  School or Department Number: _______________________
Work __________________________  Contract or Hourly Employee: __________________________

I wish to apply for use of the Brevard Public Schools Sick Leave Bank for the length of time specified herein and under the conditions and restrictions as described in the official Sick Leave Bank guidelines as adopted by Brevard Public Schools.

I am a member of the Brevard Public Schools Sick Leave Bank and hereby request:

Number of days: _______________________

Date from: ___________________________  Date through: ___________________________

Date sick leave exhausted (if known) _______________________________________

I have read, understand, and agree to adhere to the official sick leave bank guidelines as adopted by the Board.

I understand, in the event my circumstances change so as to require the use of less than the total days applied for herein, it is my duty to notify my Supervisor in writing of such change and the reason therefore.

I understand that statements from a licensed medical doctor covering the total number of days requested and a completed Leave of Absence form must accompany this application.

____________________________________________  __________________________
Signature of Applicant                             Date

Please check the following:

☐ Detailed doctor’s statement attached
☐ Copy of Leave of Absence form signed by supervisor attached
☐ Original signed Authorization for Release of Health Information attached
☐ Is this a pre-existing condition? Yes/No
Not answering may delay application processing.

Note: If on a Long Term Disability claim Sick Bank is considered a deductible source of income.

APPLICANT IS TO SIGN AND SEND ALL COPIES TO PAYROLL

To be completed by sick leave bank committee:

Number of days approved _______________________

Request disapproved _______________________

__________________________
Signature of Sick Leave Bank Committee Representative

Reason disapproved _______________________

__________________________
Acknowledged for Processing:

__________________________
Assistant Superintendent for Human Resource Services

08/08
What you should know about your employee benefits as you go on an approved Unpaid Leave of Absence

You may continue your employee benefits (health care, dental, vision, disability, etc.) while you are on an approved unpaid leave of absence. With the exception of leave under the Family Medical Leave Act (FMLA) and extended illness leave (limited to 60 days and not available if you are eligible for FMLA), you must pay the entire cost of your benefits while you are on leave. Your benefits will continue or be cancelled based upon the acknowledgment you indicated on your leave of absence form. Should you choose to retain your benefits, but fail to pay for your employee benefits costs to the School Board of Brevard County while you are on leave, it will result in the automatic cancellation of your benefits. Benefits cancelled for non-payment will not be eligible for reinstatement until you return to work by completing an Employee Flexible Enrollment Form. However, if you allow your medical benefits to terminate for non-payment and a lapse of more than sixty three (63) days occurs between the termination date and the next opportunity you have to enroll, your re-enrollment may be governed by certain limitations, such as pre-existing conditions and the requirements of providing Evidence of Insurability (EOI) for certain benefit plans. The following rules are for the cancellation of employee life, dependent life, and either of the disability coverage’s while on leave:

JOINT COVERAGE: When you go on an approved unpaid leave of absence you lose eligibility for joint coverage (unless on FMLA) for health care coverage. Joint coverage is only available when both spouses are actively at work in a benefit-generating position or one is on FMLA leave; they are both enrolled in one of our health care plans; and they are covering dependent children. The loss of joint status is effective the first day of your unpaid leave of absence. An automatic change will be made to the health care coverage for the active spouse to “Employee and Children” and for the spouse on leave of absence to “Employee Only” unless you submit a flex enrollment form stating otherwise. One employee may not cover another employee at anytime for any benefit other than dental.

For more information about your benefits while on leave, go to http://benefits.brevard.k12.fl.us/HR/LOA/LOAHome.html or talk to the Benefits Contact person at your worksite.

If you are a member of a bargaining unit, see your negotiated bargaining unit agreement for information that may be specific to you.

EMPLOYEE LIFE INSURANCE: If coverage was cancelled either by you or for non-payment your basic coverage will be reinstated upon your return to work. Additional coverage can only be increased at one times your salary during the annual Open Enrollment period. This can be done for the next three Open Enrollments until you are at the maximum of three times your annual salary for additional coverage, with a total of four times your annual salary. If coverage is continued during your leave then the same level of coverage can continue upon your return.

DEPENDENT LIFE INSURANCE: If you were cancelled for nonpayment, you may request reinstatement through the Evidence of Insurability process which will need to be approved by the carrier. Remember, coverage can be denied due to any health issue. If coverage is continued during your leave then the same level of coverage can continue upon your return.

Note: If you experience a Change of Family Status event, adding or deleting dependents from life insurance coverage can be done at any time while you are on an approved unpaid leave of absence, but MUST be done within 30 days of the event. If you add dependents to coverage, that change is not effective until you return to an active employment status.

WAIVER OF EMPLOYEE AND DEPENDENT LIFE: If you have maintained coverage and are on a medical leave for more than 180 days you may apply for waiver of premium. You will need to contact Debbie Lucas at 633-1000 ext. 648 in order to obtain the necessary forms. Once approved, up to 12 months of premiums will be returned to you based upon the leave period and the approval time.

If totally disabled before the age of 60, the coverage with waiver can be maintained until age 70. The amount of insurance eligible for waiver of premium is the amount in effect on the day before you become totally disabled as an active at-work employee.
DISABILITY COVERAGES: May be maintained for 13 weeks while you are on an approved personal (not medically related) unpaid leave of absence. As long as you maintain disability coverage for 13 weeks, your coverage will be reinstated when you return to work. If you do not maintain coverage for the full 13-week period, you will be required to go through the Evidence of Insurability (EOI) process during the next Open Enrollment period and coverage can be denied by the vendor due to any health issue. To avoid EOI, do not let your disability coverage expire before you have completed 13 weeks of coverage.

DISABILITY: You do not have to exhaust all of your paid sick leave prior to applying for Short Term Disability (STD). Paid sick leave, sick bank and vacation can also be used while you are collecting STD benefits. There is a 14-day elimination period before your STD benefits begin. This 14-day count starts the day after the last day you were actively at work or from the date of disability and includes weekends. You may use paid sick leave, sick bank or vacation during the 14-day elimination period.

Disability benefits are equal to 60 percent of your annual salary. Benefits are paid based upon your annual salary and are divided by 52 weeks per year, not by the number of weeks you work per year.

To apply for disability benefits call Hartford at 1-800-303-9744. The process is paperless, unless you only have Long Term Disability (LTD) coverage. There is a 180 day elimination period for LTD, but you can be receiving STD benefits during that time. While you are on an approved leave of absence and receiving short term disability benefits, your disability coverage can not be cancelled and you must continue to pay premiums. Once you have been off of work because of a disability for 180 days or your STD benefits have expired and you begin receiving LTD benefits, you do not have to pay any further disability coverage premiums; this is called a Waiver of Premium.

Dependent Care Flexible Spending Account: Per IRS regulations, Dependent Care Flexible Spending Accounts end on the last date worked prior to the Leave of Absence. Both parents must be actively at work or at in school in order to be reimbursed for child daycare expenses. Once on Leave, you may still send in receipts for reimbursement for dates of service prior to your Leave.

When you return to work, you may re-enter the Dependent Care plan with either 1) the same election amount, and the payroll deductions will be adjusted, or 2) the same payroll deductions as before the LOA, and the election will be adjusted, but not by less than the disbursed balance.

Medical Flexible Spending Account: Medical Flexible Spending Accounts can be continued during a Leave of Absence if you choose, or can be suspended during your Leave. If you elect to continue participating in the Medical Flexible Spending Account, you will continue to pay into the account as you would if you were still actively at work. If you are on an unpaid leave, the contributions you make will be with after-tax dollars. If you elect to continue paying into the Medical Flexible Spending Account during your Leave, you will be able to access that account through your debit card or apply for reimbursement during your Leave. If you do not elect to continue paying into the account, you will not have access to your Medical Flexible Spending Account after your last day worked. You would still be eligible to receive reimbursement for dates of service prior to your Leave.

When you return from a Leave, you may re-enter the Medical Flexible Spending Account plan with either 1) the same election amount, and the payroll deductions will be adjusted, or 2) the same payroll deductions as before the LOA, and the election will be adjusted, but not by less than the disbursed balance.

Vacation and Sick leave: Do not accrue while you are on an approved unpaid leave of absence.

Changes in coverage: You may change your employee benefit when you go on an approved unpaid leave of absence within 30 days of the leave begin date and once again within 30 days of your return to work from such a leave. The only other time you can make a change to your coverage MUST be made while you are on leave if you have a Change in Family Status (birth, death, divorce, etc.). Remember: A change in benefits that is the result of a Change in Family Status must be made within 30 calendar days of the event even while you are on an approved unpaid leave of absence.

Returning to work from an approved unpaid leave of absence - If you are on an approved leave of absence because of illness, you may not return to work without a release from your doctor. Unless your illness or injury is related to a Worker's Compensation situation, you may not return to work with any physical or mental restrictions if you are a Classroom Instructor or Instructor's Assistant. Non-instructional employees must have return-to-work instructions reviewed and approved by their Administrator or Supervisor so their return-to-work request can be approved or denied.

7/01/2008
**2008 Flex Plan Enrollment**

This Enrollment Form Must be Filled Out Completely - NO Blank Coverage Elections Allowed.

- Return From Leave
- Joint Family
- Job Share
- Re-Hire
- Enroll
- Effective Date

**Change**  
NOTE: ALL CHANGE REQUESTS MUST BE ACCOMPANIED BY SUPPORTING DOCUMENTATION AND RECEIVED BY COMPENSATION AND BENEFITS WITHIN 30 DAYS FOLLOWING THE EVENT

<table>
<thead>
<tr>
<th>Name</th>
<th>Employee ID #</th>
<th>Site No.</th>
</tr>
</thead>
</table>

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* Premiums listed on this enrollment form are **MONTHLY AMOUNTS**

To calculate your per pay cost, multiply the monthly premium cost by 12 and divide that amount by your pay frequency.

### MEDICAL

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Employee Only Cost</th>
<th>Employee + Spouse Cost</th>
<th>Employee + Children Cost</th>
<th>Employee + Family Cost</th>
<th>Joint Employee + Children Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre-tax</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>CIGNA Basic Plan</td>
<td>0.00</td>
<td>128.82</td>
<td>92.35</td>
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<td>BCBSFL BlueCare</td>
<td>21.67</td>
<td>358.87</td>
<td>193.27</td>
<td>476.47</td>
<td>37.83</td>
</tr>
<tr>
<td>CIGNA EPO</td>
<td>21.67</td>
<td>358.87</td>
<td>193.27</td>
<td>476.47</td>
<td>37.83</td>
</tr>
<tr>
<td>BCBSFL BlueChoice</td>
<td>43.27</td>
<td>403.27</td>
<td>217.27</td>
<td>548.47</td>
<td>73.84</td>
</tr>
<tr>
<td>CIGNA PPO</td>
<td>43.27</td>
<td>403.27</td>
<td>217.27</td>
<td>548.47</td>
<td>73.84</td>
</tr>
</tbody>
</table>

**Opt Out of Medical**  
$54.57 monthly credit for Opt Out

**No Medical Coverage or Opt Out Money**  
no credit given for no coverage

### DELTA DENTAL

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Employee Only Cost</th>
<th>Employee + One Cost</th>
<th>Employee + Two or More Cost</th>
<th>Facility Number</th>
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<tbody>
<tr>
<td>DeltaCare USA Low</td>
<td>8.45</td>
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<tr>
<td>DeltaCare USA High</td>
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<td>27.09</td>
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<td>Low PPO</td>
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<td>High PPO</td>
<td>30.74</td>
<td>60.99</td>
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<td>No Dental Coverage</td>
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### VISION

(Employee Only coverage is provided by the School Board at no cost to employee)

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Employee Only Cost</th>
<th>Employee + One Cost</th>
<th>Employee + Two or More Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6.78</td>
<td>14.85</td>
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</table>

### BASIC EMPLOYEE 1 TIMES LIFE INSURANCE

(Basic 1 times Employee life is paid for by the School Board at no cost to the employee)

### ADDITIONAL EMPLOYEE LIFE INSURANCE

<table>
<thead>
<tr>
<th>Pay Frequency</th>
<th>Employee Only</th>
<th>Employee + Family</th>
<th>No AD&amp;D Coverage</th>
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</thead>
<tbody>
<tr>
<td>1 x Pay</td>
<td></td>
<td></td>
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<tr>
<td>2 x Pay</td>
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<td>3 x Pay</td>
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<td>4 x Pay</td>
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### ACCIDENTIAL DEATH & DISMEMBERMENT

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<th>Pay Frequency</th>
<th>Employee Only</th>
<th>Employee + Family</th>
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<td>1 x Pay</td>
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<td>2 x Pay</td>
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<td>3 x Pay</td>
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<td>4 x Pay</td>
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### DEPENDENT LIFE INSURANCE

<table>
<thead>
<tr>
<th>Pay Frequency</th>
<th>Option 1</th>
<th>Option 2</th>
<th>No Dependent Life Coverage</th>
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<tbody>
<tr>
<td>1 x Pay</td>
<td>$3.01</td>
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</tr>
<tr>
<td>2 x Pay</td>
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<td>$5.83</td>
<td></td>
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<tr>
<td>3 x Pay</td>
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<tr>
<td>4 x Pay</td>
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</tbody>
</table>

Spouse $5,000; each eligible child $2,500

-or-

Each eligible child $2,500

Spouse $10,000; each eligible child $2,500

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ENROLLMENT CONTINUES ON OTHER SIDE
BREVARD PUBLIC SCHOOLS

2008 Flex Plan Enrollment (continued)

| DISABILITY INSURANCE | Short Term Disability | No Short Term Disability Coverage |
| Long Term Disability | No Long Term Disability Coverage |

Post-tax

| Health Care Flexible Spending Account (HCFSA) | Must be entered as the per pay amount contributed | (Maximum $5,000.00/ Minimum $200.00 annual) |
| Employee Contribution | $ | No Contribution |

| Dependent Care Flexible Spending Account (DCFSA) | Must be entered as the per pay amount contributed | (Maximum $5,000.00/ Minimum $200.00 annual) |
| Employee Contribution | $ | No Contribution |

SECTION 125 CREDIT

(Find your Per Pay Credit on the Benefits Cost Per Pay Period sheet in your packet)

| Coverage | Per Pay Credit | $5.00 per pay minimum |
| Medical | | |
| Dental | | |
| Vision | | |
| Health Care Flexible Spending Account | | |
| Dependent Care Flexible Spending Account | | |

School Board gives each employee $200.00 a year
This credit can be used to offset a premium amount
or can be used to allocate it to a Flexible Spending Account

LONG TERM CARE (LTC) OPTION

Long Term Care premiums are NOT deducted from pay. Premiums will be direct billed to the Employee’s residence.

For Long Term Care Enrollment and premium information please contact CNA directly at 1-877-777-9072

AFLAC - PERSONAL CANCER PROTECTOR PLAN

Pre-tax

Premiums can be deducted from your pay. For information about this plan go to www.aflacclients.com/brevard
The password is (brevard) You can call 1-866-932-3522 or call a local agent at 987-9830 or 288-4084

Dependents To Be Insured (Complete for each covered dependent)

<table>
<thead>
<tr>
<th>Dependent Name</th>
<th>Soc. Sec. No.</th>
<th>Date of Birth</th>
<th>Relationship</th>
<th>Med</th>
<th>Dent</th>
<th>Vis</th>
<th>Life</th>
<th>AD&amp;D</th>
<th>Facility No.</th>
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Please Read and Sign Below

I hereby request the group coverage for which I am eligible and authorize deductions from my earnings to serve as payment for any required contributions.

I authorize any physician, other health professional, all hospitals and other health care institutions to provide the contracted physicians and any independent claim administrators, consulting health professionals and utilization review organizations with whom any plan has contracted, information concerning health care advice, treatment or supplies provided my dependents and/or myself (including those involving mental illness) relating to coverage under this plan. This information will be used for coordinating patient care, evaluating and administering claims for benefits, and for fulfilling obligations imposed on the plans by Federal or State law. My signature below affirms that all information and statements provided on this form are full, complete and true to the best of my knowledge.

* Due to system calculations there may be a variance due to rounding*

Employee Signature: ________________________________ Date: ____________________________

Side B 2008 Enrollment 6.26.08
Dear Brevard Public Schools Employee:

To avoid termination of benefits for non-payment of premiums while on unpaid leave of absence, you will be responsible for remitting premiums to Brevard County School Board at ESF Viera for the benefits that you and any eligible dependents have elected for the current plan year.

Brevard County School Board, Office of Compensation & Benefits will mail a monthly benefit premium invoice reflecting the benefits in which you and/or eligible dependents are currently enrolled. This will be based on your bi-weekly pay schedule.

All payments are due by the date indicated on the invoice. If the due date has passed, the employee will be responsible for remitting payments. If payments are not received in a timely fashion, the employee may face termination of benefits. Please note that under provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPPA), if you allow benefits to lapse for non-payment for 63 days or longer, you will be subject to certain pre-existing conditions and/or evidence of insurability requirements upon re-enrollment.

If you have not received your monthly invoice, or if you have questions regarding your leave of absence account, please contact Office of Compensation & Benefits at 321-633-1000 ext. 248.

Brevard County School Board

Office of Compensation & Benefits
**NOTE:** This form is to be completed when you have been released by your physician to return to work from your medical leave. You must have your healthcare provider certify that you are able to return to work and the effective date. You will not be permitted to resume work until healthcare provider certifies that you are able to perform the essential functions of your job. Return the form to the Compensation & Benefits Office prior to your request to return to work.

### PART I: EMPLOYEE INFORMATION (to be completed by Employee)

<table>
<thead>
<tr>
<th>Employee Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>School/Dept:</td>
</tr>
<tr>
<td>Job Title:</td>
</tr>
<tr>
<td>Employee ID #:</td>
</tr>
</tbody>
</table>

**Date Leave of Absence Began:** Date: ___ / ___ / ___.

☐ Date Employee Will Return to Work:

☐ Employee IS NOT returning to work. Separation Date is:

Employee’s Signature:

### PART II: CERTIFICATION OF QUALIFYING CONDITION (to be completed by the Health Care Provider)

<table>
<thead>
<tr>
<th>Name of Health Care Provider:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Health Care Practice:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Phone:</td>
</tr>
<tr>
<td>Date of Examination:</td>
</tr>
</tbody>
</table>

| Name of Employee:          |
| Name of Patient:           |

I certify that _____ is able to perform the essential functions of his/her job without restrictions effective Date: ___ / ___ / ___.

Please indicate if restrictions apply. If yes please describe limitations:

☐ YES  ☐ NO

Return to Work date: Date: ___ / ___ / ___.

**CERTIFICATION:** I affirm that the information provided above is true and accurate to the best of my knowledge.

Signature-Health Care Provider: (do not use stamp or designee signature)

Date: