

## Lower Township Board of Education

905 Seashore Road, Cape May NJ 08204

Phone: 609-884-9400

### LEAVE OF ABSENCE REQUEST FORM

**\*\*ALL LEAVES MUST BE REQUESTED 30 DAYS IN ADVANCE\*\*  
OR AS SOON AS FORESEEABLY POSSIBLE**

All leaves must be requested from and granted by the Board in accordance with policies:

3431.1 FAMILY LEAVE	Teaching Staff Members
4431.1 FAMILY LEAVE	Support Staff

- The Leave of Absence Request Form requires notification to the Superintendent, or his designee.
- If approved by the Board of Education, you will be notified by Patti Jacob, Secretary to the Superintendent, after the said approval.
- Both the FMLA and NJFLA will be run concurrently.
- All accrued sick time must be exhausted during the FMLA period.

#### FORM INSTRUCTIONS:

1. Please have Tricia Ryan, Payroll Supervisor, complete Section I of the Leave of Absence form.
2. The employee requesting the leave of absence, must complete Section II.
3. The employee's Health Care Provider must complete Section III.
4. Once all sections of the packet have been completed, please return to Patti Jacob, Secretary to the Superintendent, including all required documents.

Note: If additional paperwork or documentation is required, you will be notified.

*Accordance with policy, 30 days written advance notice to the Superintendent if the need for the leave is foreseeable ~refer to policy*

*If thirty days is not practical, the staff member must provide notice "as soon as practicable"  
~refer to policy*

#### OFFICE USE ONLY:

Copies of the completed Leave of Absence form must be provided to the following:

Jeff Samaniego, Superintendent

John Hansen, Board Secretary

Tricia Ryan, Payroll Supervisor

Lower Township Board of Education  
905 Seashore Road, Cape May NJ 08204  
Phone: 609-884-9400

**LEAVE OF ABSENCE REQUEST FORM**

(ALL LEAVES MUST BE REQUESTED 30 DAYS IN ADVANCE, OR AS SOON AS FORESEEABLY POSSIBLE)

DATE OF REQUEST:        /        /       

Name: \_\_\_\_\_

1) TYPE OF LEAVE REQUESTED: (Contact Tricia Ryan, Payroll Supervisor, to complete Employer section 1 for FMLA)

- |   |  |
|---|--|
| <input type="checkbox"/> Maternity/Paternity {FMLA/FLA}                                 | <i>Health care provider certification required</i> |
| <input type="checkbox"/> Medical/Sick Leave- Employee {FMLA}                            | <i>Health care provider certification required</i> |
| <input type="checkbox"/> Seriously ill Spouse, Child, Parent or<br>Dependent {FMLA/FLA} | <i>Health care provider certification required</i> |
| <input type="checkbox"/> Adoption/Foster Child Placement {FMLA}                         | <i>Attach documentation</i>                        |
| <input type="checkbox"/> Military   | <i>Attach orders</i>                               |
| <input type="checkbox"/> Personal   | <i>Detailed explanation must be attached</i>       |

2) Is this an initial request: \_\_\_\_\_ or and extension: \_\_\_\_\_ {CHECK ONE}

2a) If extension: When did your initial leave begin:        /        /       

3) Have you had a Leave of Absence in the past 24 months? ( ) YES ( ) NO

3a) If yes: please give dates: When did it start?        /        /         
When did it end?        /        /       

4) Date of leave to begin:        /        /         
Date of leave to end:        /        /       

5) Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6) If Maternity:  
Expected Date of Child's Birth:        /        /       

I have been given information on my rights under the Family and Medical Leave Act (FMLA) and NJ Family Leave Act (FLA)

Employee's Signature	<u>      </u> / <u>      </u> / <u>      </u> Date
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**NOTE: SUBMIT COMPLETED FORM WITH ALL ATTACHMENTS TO Patti Jacob, Secretary to Superintendent.**

**OFFICE USE ONLY:**

Date Received: <u>      </u> / <u>      </u> / <u>      </u>	Approved: Y/N <u>      </u> / <u>      </u> / <u>      </u>
Board Approval Date: <u>      </u> / <u>      </u> / <u>      </u>	Denied: Y/N <u>      </u> / <u>      </u> / <u>      </u>
Comments:	
<input type="checkbox"/> Incomplete <input type="checkbox"/> needs Certificate of Health Care Provider	
<input type="checkbox"/> Returned to employee for additional documentation: Date <u>      </u> / <u>      </u> / <u>      </u>	
<input type="checkbox"/> Other:	

**Copy of Leave of Absence Request Form to:**

Jeff Samaniego	Superintendent
John J. Hansen	Board Secretary
Tricia Ryan	Payroll

**Attachments:**

FMLA  
FLA  
Certification of Health Provider (2)  
For Employee or For Family Member

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

U.S. Department of Labor

Wage and Hour Division



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

OMB Control Number: 1235-0003  
Expires: 5/31/2018

**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: LOWER TOWNSHIP BOARD OF EDUCATION, TRICIA RYAN 609-884-9400 XT 2606

Employee's job title: \_\_\_\_\_ Regular work schedule: \_\_\_\_\_

Employee's essential job functions: \_\_\_\_\_

Check if job description is attached: \_\_\_\_\_

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II 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. 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. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: \_\_\_\_\_  
First Middle Last

**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the employee's family members, 29 C.F.R. § 1635.3(b). Please be sure to sign the form on the last page.

Provider's name and business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

**PART A: MEDICAL FACTS**

1. Approximate date condition commenced: \_\_\_\_\_

Probable duration of condition: \_\_\_\_\_

**Mark below as applicable:**

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

☐ No ☐ Yes. If so, dates of admission:

\_\_\_\_\_

Date(s) you treated the patient for condition:

\_\_\_\_\_

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

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

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

\_\_\_\_\_

2. Is the medical condition pregnancy? ☐ No ☐ Yes. If so, expected delivery date: \_\_\_\_\_

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

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

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 (such 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 his/her medical condition, including any time for treatment and recovery? ☐ No ☐ Yes.

If so, estimate the beginning and ending 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? ☐ No ☐ Yes.

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

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 \_\_\_\_\_ through \_\_\_\_\_

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

Is it medically necessary for the employee to be absent from work during the flare-ups?  
☐ No ☐ Yes. If so, 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 have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode

**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.**

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date

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

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

Certification of Health Care Provider for  
**Family Member's Serious Health Condition**  
(Family and Medical Leave Act)

U.S. Department of Labor  
Wage and Hour Division



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

OMB Control Number: 1235-0003  
Expires: 5/31/2018

**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies, and in accordance with 29 C.F.R. § 1635.9, if the Genetic Information Nondiscrimination Act applies.

Employer name and contact: LOWER TOWNSHIP BOARD OF EDUCATION

TRICIA RYAN 609-884-9400 XT 2606

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II 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. 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. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name:

First

Middle

Last

Name of family member for whom you will provide care:

First

Middle

Last

Relationship of family member to you:

If family member is your son or daughter, date of birth:

Describe care you will provide to your family member and estimate leave needed to provide care:

Employee Signature

Date

**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**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 answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), or genetic services, as defined in 29 C.F.R. § 1635.3(e). Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

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?

☐ No ☐ Yes. If so, dates of admission: \_\_\_\_\_

Date(s) you treated the patient for condition: \_\_\_\_\_

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

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

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

☐ No ☐ Yes. If so, state the nature of such treatments and expected duration of treatment:

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

2. Is the medical condition pregnancy? ☐ No ☐ Yes. If so, expected delivery date: \_\_\_\_\_

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such 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 and recovery? ☐ No ☐ Yes.

Estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

During this time, will the patient need care? ☐ No ☐ Yes.

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

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

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

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Explain the care needed by the patient, and why such care is medically necessary: \_\_\_\_\_

---

6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ☐ No ☐ Yes.

Estimate the hours the patient needs care on an intermittent basis, if any:

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

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

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7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? \_\_\_\_ No \_\_\_\_ Yes.

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 \_\_\_\_ week(s) \_\_\_\_ month(s)

Duration: \_\_\_\_ hours or \_\_\_\_ day(s) per episode

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

Explain the care needed by the patient, and why such care is medically necessary: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Health Care Provider \_\_\_\_\_ Date \_\_\_\_\_

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

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

## Fact Sheet #28: The Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons. This fact sheet provides general information about which employers are covered by the FMLA, when employees are eligible and entitled to take FMLA leave, and what rules apply when employees take FMLA leave.

### COVERED EMPLOYERS

The FMLA only applies to employers that meet certain criteria. A **covered employer** is a:

- Private-sector employer, with 50 or more employees in 20 or more workweeks in the current or preceding calendar year, including a joint employer or successor in interest to a covered employer;
- Public agency, including a local, state, or Federal government agency, regardless of the number of employees it employs; or
- Public or private elementary or secondary school, regardless of the number of employees it employs.

### ELIGIBLE EMPLOYEES

Only eligible employees are entitled to take FMLA leave. An **eligible employee** is one who:

- Works for a *covered employer*;
- **Has worked for the employer for at least 12 months;**
- **Has at least 1,250 hours of service for the employer during the 12 month period immediately preceding the leave\*;** and
- Works at a location where the employer has at least 50 employees within 75 miles.

\* Special hours of service eligibility requirements apply to airline flight crew employees. See Fact Sheet 28J: Special Rules for Airline Flight Crew Employees under the Family and Medical Leave Act.

The 12 months of employment do not have to be consecutive. That means any time previously worked for the same employer (including seasonal work) could, in most cases, be used to meet the 12-month requirement. If the employee has a break in service that lasted seven years or more, the time worked prior to the break will not count *unless* the break is due to service covered by the Uniformed Services Employment and Reemployment Rights Act (USERRA), or there is a written agreement, including a collective bargaining agreement, outlining the employer's intention to rehire the employee after the break in service. See "FMLA Special Rules for Returning Reservists".

### LEAVE ENTITLEMENT

Eligible employees may take up to **12 workweeks** of leave in a 12-month period for one or more of the following reasons:

- The birth of a son or daughter or placement of a son or daughter with the employee for adoption or foster care;
- To care for a spouse, son, daughter, or parent who has a serious health condition;
- For a serious health condition that makes the employee unable to perform the essential functions of his or her job; or
- For any qualifying exigency arising out of the fact that a spouse, son, daughter, or parent is a military member on covered active duty or call to covered active duty status.

An eligible employee may also take up to **26 workweeks** of leave during a "single 12-month period" to care for a covered servicemember with a serious injury or illness, when the employee is the spouse, son, daughter, parent, or next of kin of the servicemember. The "single 12-month period" for military caregiver leave is different from the 12-month period used for other FMLA leave reasons. *See Fact Sheets 28F: Qualifying Reasons under the FMLA and 28M: The Military Family Leave Provisions under the FMLA.*

Under some circumstances, employees may take FMLA leave on an intermittent or reduced schedule basis. That means an employee may take leave in separate blocks of time or by reducing the time he or she works each day or week for a single qualifying reason. When leave is needed for planned medical treatment, the employee must make a reasonable effort to schedule treatment so as not to unduly disrupt the employer's operations. If FMLA leave is for the birth, adoption, or foster placement of a child, use of intermittent or reduced schedule leave requires the employer's approval.

Under certain conditions, employees may choose, or employers may require employees, to "substitute" (run concurrently) accrued paid leave, such as sick or vacation leave, to cover some or all of the FMLA leave period. An employee's ability to substitute accrued paid leave is determined by the terms and conditions of the employer's normal leave policy.

## NOTICE

Employees must comply with their employer's usual and customary requirements for requesting leave and provide enough information for their employer to reasonably determine whether the FMLA may apply to the leave request. Employees generally must request leave 30 days in advance when the need for leave is foreseeable. When the need for leave is foreseeable less than 30 days in advance or is unforeseeable, employees must provide notice as soon as possible and practicable under the circumstances.

When an employee seeks leave for a FMLA-qualifying reason for the first time, the employee need not expressly assert FMLA rights or even mention the FMLA. If an employee later requests additional leave for the same qualifying condition, the employee must specifically reference either the qualifying reason for leave or the need for FMLA leave. *See Fact Sheet 28E: Employee Notice Requirements under the FMLA .*

Covered employers must:

- (1) Post a notice explaining rights and responsibilities under the FMLA. Covered employers may be subject to a civil money penalty for willful failure to post. For current penalty amounts, see [www.dol.gov/whd/fmla/applicable\\_laws.htm](http://www.dol.gov/whd/fmla/applicable_laws.htm);
- (2) Include information about the FMLA in their employee handbooks or provide information to new employees upon hire;

- (3) When an employee requests FMLA leave or the employer acquires knowledge that leave may be for a FMLA-qualifying reason, provide the employee with notice concerning his or her eligibility for FMLA leave and his or her rights and responsibilities under the FMLA; and
- (4) Notify employees whether leave is designated as FMLA leave and the amount of leave that will be deducted from the employee's FMLA entitlement.

See Fact Sheet 28D: Employer Notice Requirements under the FMLA.

## **CERTIFICATION**

When an employee requests FMLA leave due to his or her own serious health condition or a covered family member's serious health condition, the employer may require certification in support of the leave from a health care provider. An employer may also require second or third medical opinions (at the employer's expense) and periodic recertification of a serious health condition. See Fact Sheet 28G: Certification of a Serious Health Condition under the FMLA. For information on certification requirements for military family leave, See Fact Sheet 28M(c): Qualifying Exigency Leave under the FMLA; Fact Sheet 28M(a): Military Caregiver Leave for a Current Servicemember under the FMLA; and Fact Sheet 28M(b): Military Caregiver Leave for a Veteran under the FMLA.

## **JOB RESTORATION AND HEALTH BENEFITS**

Upon return from FMLA leave, an employee must be restored to his or her original job or to an equivalent job with equivalent pay, benefits, and other terms and conditions of employment. An employee's use of FMLA leave cannot be counted against the employee under a "no-fault" attendance policy. Employers are also required to continue group health insurance coverage for an employee on FMLA leave under the same terms and conditions as if the employee had not taken leave. See Fact Sheet 28A: Employee Protections under the Family and Medical Leave Act .

## **OTHER PROVISIONS**

Special rules apply to employees of local education agencies. Generally, these rules apply to intermittent or reduced schedule FMLA leave or the taking of FMLA leave near the end of a school term.

Salaried executive, administrative, and professional employees of covered employers who meet the Fair Labor Standards Act (FLSA) criteria for exemption from minimum wage and overtime under the FLSA regulations, 29 CFR Part 541, do not lose their FLSA-exempt status by using any unpaid FMLA leave. This special exception to the "salary basis" requirements for FLSA's exemption extends only to an eligible employee's use of FMLA leave.

## **ENFORCEMENT**

It is unlawful for any employer to interfere with, restrain, or deny the exercise of or the attempt to exercise any right provided by the FMLA. It is also unlawful for an employer to discharge or discriminate against any individual for opposing any practice, or because of involvement in any

proceeding, related to the FMLA. *See Fact Sheet 77B: Protections for Individuals under the FMLA*. The Wage and Hour Division is responsible for administering and enforcing the FMLA for most employees. Most federal and certain congressional employees are also covered by the law but are subject to the jurisdiction of the U.S. Office of Personnel Management or Congress. If you believe that your rights under the FMLA have been violated, you may file a complaint with the Wage and Hour Division or file a private lawsuit against your employer in court.

**For additional information, visit our Wage and Hour Division Website:**

**<http://www.wagehour.dol.gov> and/or call our toll-free information and helpline, available 8 a.m. to 5 p.m. in your time zone, 1-866-4-USWAGE (1-866-487-9243).**

This publication is for general information and is not to be considered in the same light as official statements of position contained in the regulations.

**U.S. Department of Labor**  
Frances Perkins Building  
200 Constitution Avenue, NW  
Washington, DC 20210

**1-866-4-USWAGE**  
TTY: 1-866-487-9243  
**Contact Us**

# Your Guide to Family Leave Insurance in New Jersey

## You can claim Family Leave Insurance benefits to:

- Bond with a newborn child during the first 12 months after the child's birth. You, your domestic partner, or your civil union partner must be the biological parent of the child.
- Bond with an adopted child during the first 12 months after the child's placement.

Bonding leave must be taken for a period of more than seven consecutive days, unless the employer permits the leave to be taken in non-consecutive periods. In this case, each leave period must be at least seven days.

- Care for a family member with a serious health condition. A health care provider must certify the condition. Care leave may be taken:
  - for six consecutive weeks
  - for intermittent weeks, or
  - for 42 intermittent days

during a 12-month period beginning with the first date of the claim.

"Family member" means your child, spouse, domestic partner, civil union partner, or parent.

"Child" means your:

- biological, adopted, or foster child; stepchild, or legal ward, or
- domestic partner's or civil union partner's child.

The child must be:

- less than 19 years old, or
- 19 years of age or older but incapable of self-care because of mental or physical impairment.

## Family Leave Insurance Facts

- Family Leave Insurance provides a monetary benefit, not a leave entitlement.
- This program does not give workers the right to return to their job after a period of family leave. Your job may be protected if your employer is subject to the federal Family and Medical Leave Act (FMLA) or the New Jersey Family Leave Act (NJFLA).
- Your employer may require you to use up to two weeks of sick leave, vacation time, or other paid time off. Employers who do this must provide full pay for this leave time.
- If your employer requires you to use up to two weeks of sick leave, vacation time, or other paid time off, the maximum Family Leave Insurance allowance may be reduced by up to 14 days.
- If you claim family leave benefits to care for a family member with a serious health condition, you must give your employer reasonable advance notice unless:
  - you need to take leave time unexpectedly, or
  - the time of the leave changes for reasons you could not foresee.
- If you claim family leave benefits intermittently, you must give your employer 15 days' notice.
- If you claim benefits to bond with a newborn or newly adopted child, you must give your employer 30 days' notice before the leave starts. If you do not give your employer the proper notice, your benefit entitlement may be reduced by 14 days.
- If you are taking intermittent leave for bonding, you must take the leave in periods of seven days or more. You and your employer must both agree to the intermittent schedule.

## Coverage

Employment covered under the New Jersey Unemployment Compensation Law, including state and local government employment, is also covered for Family Leave Insurance. We call this "covered employment."

Employees may be covered under:

- the State Plan;
- an approved Private Plan; or
- Family Leave During Unemployment (if the period of leave begins more than 14 days after the last day of covered employment).

Employers must post information about the type of coverage provided at the worksite.

## Cost

The program is financed by worker payroll deductions. Starting January 1, 2018, each worker contributes 0.09% of the taxable wage base. For 2018, the taxable wage base is \$33,700, and the maximum yearly deduction for Family Leave Insurance is \$30.33. The taxable wage base changes each year.

Employers do not contribute to the program.

## Applying for Benefits

You can apply online for Family Leave Insurance benefits:

- At [www.nj.gov/labor/fli2](http://www.nj.gov/labor/fli2)
- Download an application (DS-1) and mail to:  
Division of Temporary Disability Insurance  
PO Box 387, Trenton, NJ 08625-0387 or fax to (609) 984-4138
- Request an application by phone (Customer Service Section): (609) 292-7060

If you are receiving State Plan temporary disability benefits for a pregnancy-related disability, we will automatically send you instructions for claiming Family Leave Insurance benefits for bonding with your newborn child.

**Important: DO NOT submit applications until your family leave claim begins. Filing early can delay your claim.**

Please allow 14 days' processing time before inquiring about a claim.

The claimant's Social Security number must appear on any correspondence or inquiry about a claim.

A claim cannot be located without the Social Security number.

People with a hearing impairment may contact us Telecommunication Device for the Deaf (TDD)  
609-292-8319

New Jersey Relay Service: TT user 1-800-852-7899

## STATE PLAN – FAMILY LEAVE INSURANCE BENEFITS

### Wage Requirements

To establish a valid claim, you must have earned a certain amount in New Jersey covered employment during your "base year." The base year is the 52 weeks immediately before the week in which the family leave begins.

You must have either:

- worked 20 calendar weeks in the base year, each being a week in which you had New Jersey earnings of \$169 or more **OR** a week (up to 13 weeks) in which you were separated from employment due to a declared state of emergency during the base year; or
- earned \$8,500 or more during the base year.

### Benefit Duration

You may receive up to six weeks of Family Leave Insurance benefits in a 12-month period. The 12-month period is the 365 consecutive days that begins on the first day that you file a valid first claim for Family Leave Insurance benefits.

A "first claim" is the first claim you file for Family Leave Insurance benefits. The 12-month period starts when you file your first claim.

A "re-established claim" is another claim filed within the same 12-month period. You may re-establish a claim:

- to care for a different family member, or
- during or following employment with a different employer.

You cannot receive more than six weeks of benefits during the 12-month period, for any reason.

### Benefit Amounts

The weekly benefit rate for a Family Leave Insurance claim is based on your average weekly wage. The average weekly wage is generally based on how much you earn in the eight weeks immediately before your claim begins. For claims beginning January 1, 2018, the weekly benefit rate is two-thirds (2/3) of your average weekly wage, up to \$637.

The daily benefit rate is one-seventh (1/7) of the weekly benefit rate.

You can receive benefits for up to six weeks (42 days) during a 12-month period, or until you receive benefits equal to one-third (1/3) of your earnings during your base year, whichever is less.

If you file a State Plan claim for Family Leave Insurance benefits immediately after an eligible State Plan temporary disability claim, in most cases, the weekly benefit amount you receive will be the same as your State Plan temporary disability benefit amount. No one may receive more than the maximum weekly benefit amount allowed by law.

### **Benefit Limitations**

The seven days after you file a claim is the “waiting week.” You will not receive benefits for this week (or any part of the first week) until benefits have been paid for the three weeks following the waiting week. However, if your family leave immediately follows leave for your own illness under State Plan temporary disability, there is no waiting period for Family Leave Insurance benefits.

If you are receiving a pension that your most recent employer contributed to on your behalf, your weekly benefit amount will be reduced by the pension payment you received.

Family Leave Insurance benefits are not payable under the State Plan for:

- Any period when you receive temporary disability benefits, workers’ compensation benefits, or any benefits from a disability or cash sickness program or similar law of New Jersey or any other state or the federal government;
- Any period when you receive unemployment insurance benefits;
- Any period when you receive full salary or paid time off (however, your employer may not require you to use more than two weeks of paid sick leave, vacation time, or other leave at full pay);
- Any period when you are working;
- Any period of family leave that did not start while you were a covered employee or within 14 days of your last day of covered employment;
- Any period of family leave to care for a family member who was not under the care or supervision of a health care provider;
- Any period you are out of work due to a labor dispute at your place of work;
- Any period after being fired by your most recent employer for gross misconduct connected with the work because you committed a criminal act punishable under the New Jersey Code of Criminal Justice; or
- Employees of educational institutions during any period between academic years or terms or during a school-wide recess, when you have a reasonable assurance of returning to work in the same or similar capacity when school resumes.

### **Impartial Examinations**

An examination may be needed to support your claim for Family Leave Insurance. We may require that the person you are caring for get a physical examination by a state-appointed physician. There is no cost to you or the care recipient. If the care recipient refuses an examination, benefits will be denied.

### **Tax Information**

Family Leave Insurance benefits are subject to federal income tax and to federal rules on reporting income and paying taxes. Family Leave Insurance benefits are not subject to New Jersey state income tax. You may choose to have 10% of your benefits withheld for federal income tax. After the end of each calendar year, form 1099G will be available online. This form lists the total benefits received that year. We also give this information to the Internal Revenue Service (IRS).

### **Appeals**

The Division of Temporary Disability Insurance will make a determination of eligibility on your claim. If you or your employer disagree with the determination, you or the employer may file a formal appeal. You must file the appeal in writing within seven calendar days after delivery of the determination, or within 10 calendar days after the decision is mailed. The appeal costs nothing. You do not need a lawyer.

## **PRIVATE PLAN – FAMILY LEAVE INSURANCE BENEFITS**

The law allows employers to use an approved Private Plan for Family Leave Insurance, instead of the State Plan. Private Plans must be equal to or better than the State Plan with regard to benefit amount and duration. Eligibility requirements may be no more restrictive than the State Plan. Workers may not pay more for Private Plan coverage than for State Plan coverage. The Division of Temporary Disability Insurance must approve all Private Plans.

Employers may use a Private Plan for temporary disability benefits and the State Plan for Family Leave Insurance benefits. Employers must post information about the type of coverage provided at the worksite.

If you are covered by a Private Plan and want to file a claim for Family Leave Insurance benefits, you must give your employer the required notice. (See "Family Leave Facts" section for requirements.) Your employer can provide the information you need to claim benefits.

The Private Plan insurer will make the decision on eligibility.

If you disagree with a decision on the Private Plan claim, you may file a complaint with:

Private Plan Compliance Section  
Claims Review Unit  
P.O. Box 957, Trenton, NJ 08625-0957

## **FAMILY LEAVE INSURANCE BENEFITS DURING UNEMPLOYMENT**

If you apply for Family Leave Insurance benefits more than 14 days after your last day of covered employment, your claim will be processed for benefits under the Family Leave During Unemployment program. People who claim Family Leave During Unemployment must meet all the eligibility requirements for unemployment benefits, but are not required to show their availability for work.

Benefits under the Family Leave During Unemployment program are paid for full weekly periods from Sunday through Saturday. Benefits are not payable for intermittent days under this program.

**Division of Temporary Disability Insurance**

**PO Box 387**

**Trenton, New Jersey**

**08625-0387**

**Claims Information:**

**609-292-7060**

**FAX:**

**609-984-4138**